Dundee City Council
Corporate Services
CHANGING FOR THE FUTURE

City Chambers
DUNDEE
DD1 3BY

15th April, 2025

Membership

Bailie Kevin Keenan
Bailie Helen Wright
Bailie Fraser Macpherson
Bailie Derek Scott
Bailie Christina Roberts
Councillor Jimmy Black
Councillor Nadia El-Nakla
Councillor Lynne Short

Dear Colleague

You are requested to attend a MEETING of the **SCRUTINY COMMITTEE** to be held remotely on Wednesday, 23rd April 2025 at 2.00 pm. Substitute members are allowed.

Members of the Press or Public wishing to join the meeting should contact Committee Services on telephone (01382) 434228 or by email at committee.services@dundeecity.gov.uk by 5.00 pm on Monday, 21st April, 2025.

Yours faithfully

GREGORY COLGAN

Chief Executive

1 DECLARATION OF INTEREST

Members are reminded that, in terms of The Councillors Code, it is their responsibility to make decisions about whether to declare an interest in any item on this agenda and whether to take part in any discussions or voting.

This will include all interests, whether or not entered on your Register of Interests, which would reasonably be regarded as so significant that they are likely to prejudice your discussion or decision-making.

2 EDUCATION SCOTLAND (HMI) INSPECTION OF ST FERGUS PRIMARY SCHOOL - Page 1

(Report No 135-2025 by the Executive Director of Children and Families Service, copy attached).

3 INSPECTION REPORT ON FOSTERING AND ADOPTION SERVICE - Page 11

(Report No 136-2025 by the Executive Director of Children and Families Service, copy attached).

4 FIRE AND RESCUE QUARTERLY PERFORMANCE REPORT - Page 57

(Report No 137-2025 by Area Commander Todd, copy attached).

5 INTERNAL AUDIT REPORTS - Page 85

(Report No 126-2025 by the Chief Internal Auditor, copy attached).

6 INTERNAL AUDIT PLAN UPDATE AND PROGRESS REPORT - Page 111

(Report No 127-2025 by the Chief Internal Auditor, copy attached).

7 2025/2026 INTERNAL AUDIT PLAN - Page 141

(Report No 128-2025 by the Chief Internal Auditor, copy attached).

8 INTERNAL AUDIT STRATEGY AND MANDATE AND CHARTER - Page 151

(Report No 129-2025 by the Chief Internal Auditor, copy attached).

9 DUNDEE CITY COUNCIL AUDIT SCOTLAND ANNUAL AUDIT PLAN 2024/2025 - Page 169

(Report No 134-2025 by the Executive Director of Corporate Services, copy attached).

10 OTHER REPORTS RELEVANT TO THE REMIT OF THE SCRUTINY COMMITTEE - Page 195

(Report No 130-2025 by the Chief Internal Auditor, copy attached).

ITEM No …2……..

REPORT TO: **SCRUTINY COMMITTEE – 23 APRIL 2025**

REPORT ON: **EDUCATION SCOTLAND VISIT – ST FERGUS RC PRIMARY SCHOOL**

REPORT BY: **EXECUTIVE DIRECTOR OF CHILDREN AND FAMILIES SERVICE**

REPORT NO: **135 – 2025**

1 PURPOSE OF REPORT

1.1 The purpose of this paper is to report on the findings of the Education Scotland, His Majesty's Inspectors of Education (HMI) visit to St Fergus RC Primary School in December 2024.

2 RECOMMENDATION

2.1 It is recommended that the Scrutiny Committee:

a notes the contents of this report; and

b instructs the Chief Education Officer to monitor progress towards meeting the areas for improvement outlined in the report.

3 FINANCIAL IMPLICATIONS

3.1 None

4 BACKGROUND

4.1 St Fergus RC Primary School was inspected by Education Scotland (HMI) in December 2024. This was a short model inspection, focused on two quality indicators as well as a focus on safeguarding. Education Scotland published a report of their findings on 4 February 2025.

4.2 St Fergus' RC Primary School is a denominational school which serves the Ardler area of Dundee. The school also incorporates an Enhanced Support Area (ESA) for children with additional and complex learning needs. At the time of inspection, the school roll was 176 children organised across seven mainstream classes and five ESA classes. There are currently 42 children supported in the ESA.

4.3 The school's current Head Teacher has been there for 6 years and has also been in a shared Headship position since November 2021. The Head Teacher is supported by an Acting Depute Head Teacher and a Principal Teacher. The Principal Teacher post was vacant at the time of inspection.

4.4 Approximately 68% of children who attend the school live in Scottish Index of Multiple Deprivation (SIMD) deciles 1 and 2. At the time of inspection, the school reported 66% of children on the roll as having additional support needs. There is approximately 47% of children in P6 and P7 registered for free school meals. The school's Pupil Equity Fund allocation is £56,350.

5 KEY INSPECTION FINDINGS

Key Strengths

The inspection team found the following strengths in the school's work.

5.1 The respectful and caring relationships between children and adults. Children are polite, well-mannered and proud of their school. They are supported well by staff to learn in a nurturing and inclusive environment.

5.2 The effective teamwork amongst staff. All staff work well to develop their individual and collective skills to help improve children's experiences and outcomes.

5.3 Staff's approaches to monitor children's progress in their learning and achievement. This is helping children across the school to make good progress in their learning.

5.4 Opportunities for children in the enhanced and specialist provisions to learn in the local and wider community. These experiences are supporting children well to develop important life skills and build confidence and resilience.

Areas for Improvement

The following areas for improvement were identified.

5.5 Teachers should ensure that all learning activities are well-matched to the needs of all children. In doing so, they should ensure the pace of learning in lessons is brisker.

5.6 Senior leaders and staff should continue to share practice to develop consistently high-quality approaches to learning and teaching across the school. This should include children more regularly leading and taking responsibility for their own learning.

5.7 Staff should help children to identify and talk about the skills they are developing through the range of activities they experience.

5.8 Appendix 1 provides a synopsis of the Summary of Inspection Findings.

6 INSPECTION EVAUATIONS

6.1 During inspections HM Inspectors gather evidence to enable them to evaluate the school and/ or nursery's work using quality indicators from How good is our school? (4th edition).

6.2 Education Scotland (HMI) reports using a six-point scale for reporting performance:

excellent	outstanding, sector leading
very good	major strengths
good	important strengths with some areas for improvement
satisfactory	strengths just outweigh weaknesses
weak	important weaknesses
unsatisfactory	major weaknesses

6.3 Here are Education Scotland's (HMI) evaluations for this inspection:

Quality Indicator	**St. Fergus Primary**
2.3 Learning, teaching, and assessment	Good
3.2 Raising attainment and achievement	Good

6.4 Education Scotland wrote to parents and carers to confirm that, as a result of the inspection findings, HM Inspectors are confident that the school has the capacity to continue to improve and so will make no more visits in connection with this inspection. Dundee City Council will inform parents and carers about the school's progress through St Fergus's RC Primary's annual School Improvement Report.

6.5 St Fergus's RC Primary School's Improvement Plans (2025/26 and beyond) will reflect Education Scotland's findings and recommendations from the Summarised Inspection Findings. Improvement Plans will be regularly reviewed, monitored, and evaluated in line with quality improvement procedures.

6.6 As part of the Children and Families Service School Improvement Framework, visits are made to the school and nursery class by the school's link Education Officers to ensure the positive improvement journey continues and monitor progress towards the action points raised in the inspection. Furthermore, as part of the Service's 'Every Dundee Learner Matters' collaborative improvement strategy the School Improvement Partnership which St Fergus RC PS is part of will continue to support and challenge nursery and school improvement.

7 POLICY IMPLICATIONS

7.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate Senior Manager has reviewed and agreed with this assessment.

8 CONSULTATIONS

8.1 The Council Leadership Team have been consulted in the preparation of this report.

9 BACKGROUND PAPERS

9.1 None.

Audrey May
Executive Director

Paul Fleming
Chief Education Officer
Head of Education, Learning and Inclusion

April 2025

APPENDIX 1

Dundee City Council

Children and Families Service

Scrutiny Committee Report Summary Notes

Inspection and Reporting

Inspection Agency	HMI
Report Publication Date	4th February 2025
Name of Establishment	St Fergus' RC Primary School
Sector	Primary
Name of Head Teacher	Mr David Bald
Roll	176

Inspection Outcomes 2025

Quality Indicator	**St Fergus's RC PS**
2.3 Learning, teaching, and assessment	**Good**
3.2 Raising attainment and achievement	**Good**

The report uses the following word scale:

excellent	outstanding, sector leading
very good	major strengths
good	important strengths with some areas for improvement
satisfactory	strengths just outweigh weaknesses
weak	important weaknesses
unsatisfactory	major weaknesses

Inspection Outcomes February 2025

Key Strengths
• The respectful and caring relationships between children and adults. Children are polite, well-mannered and proud of their school. They are supported well by staff to learn in a nurturing and inclusive environment. • The effective teamwork amongst staff. All staff work well to develop their individual and collective skills to help improve children's experiences and outcomes. • Staff's approaches to monitor children's progress in their learning and achievement. This is helping children across the school to make good progress in their learning. • Opportunities for children in the enhanced and specialist provisions to learn in the local and wider community. These experiences are supporting children well to develop important life skills and build confidence and resilience.

Areas for Improvement
• Teachers should ensure that all learning activities are well-matched to the needs of all children. In doing so, they should ensure the pace of learning in lessons is brisker. • Senior leaders and staff should continue to share practice to develop consistently high-quality approaches to learning and teaching across the school. This should include children more regularly leading and taking responsibility for their own learning. • Staff should help children to identify and talk about the skills they are developing through the range of activities they experience.

Synopsis – Summary of Inspection Findings
Following publication of the inspection report and Summarised Inspection Findings, the School's next Improvement Plan 2025/26 will reflect the areas for improvement identified by HMI and provide a clear strategic focus for related school improvement. The Summarised Inspection Findings highlighted the following strengths and areas for improvement within each of the quality indicators.

QI 2.3 – Learning, teaching and assessment
• Across the school community there is a strong, nurturing ethos. All staff are caring in their positive interactions with children. The school values of love, respect, happiness and kindness are well established and displayed clearly around the school and in classrooms. These reflect a clear commitment to the Gospel Values and the Catholic identity of the school. Staff and children model the school values well in their daily interactions. Most children feel that they are treated with respect and are encouraged to express their views and opinions. • Staff ensure positive relationships underpin their response to behaviour and use the principles of emotional regulation to support children. Staff have considered the impact of learning environments on children. They have developed calm spaces in classrooms which children access when necessary to regulate their emotions. Where behaviour is a barrier to learning, staff support children effectively using scripting and restorative approaches. The local authority provides targeted training for staff in areas such as de-escalation and nurturing principles. Staff in school have benefited from this training. Senior leaders have supported staff

effectively to improve consistency in responding to children's behaviour. As a result, incidents of disruptive behaviour have reduced significantly.

- Most children are motivated and engaged in their learning when they work independently, in pairs and in groups. In a few lessons, children become disengaged when learning is overly teacher led. Senior leaders should continue to support staff to ensure the pace of learning across the school is appropriate to meet the needs of all learners.

- Staff have worked together to develop a helpful learning and teaching standard which identifies expectations and features of effective practice. This is supporting staff to have a shared understanding of expectations across the school. In most lessons, teachers' explanations and instructions are clear.

- In most lessons, teachers provide constructive and helpful feedback to support children to know where they are in their learning. Most teachers use questioning effectively to elicit information and check children's understanding well.

- In most lessons, teachers, aided by support staff, ensure that children are supported well when they require additional help in their learning. Staff identify children who are facing additional challenges, and they provide effective support to help children overcome barriers to learning. Moving forward, senior leaders should work with teachers to ensure that all children experience a level of challenge consistent with their abilities.

- Staff engage well with national guidance and professional learning to develop play at early level. Teachers should continue to keep the balance of teacher- and child led play under review to support explicit teaching of literacy and numeracy.

- Staff use a range of digital technology successfully to support class lessons. Children use digital devices appropriately to play games to reinforce learning, undertake research and for word processing. They use an online platform to share examples of work with their parents. In addition, digital assistive technology supports children who require support with learning to access learning experiences independently.

- Teachers recently reviewed the approaches to assessment they use to check children's progress in learning. They use a range of ongoing, periodic and summative assessments. They use assessment information effectively to identify targeted support and interventions for those children who are not making expected progress. Teachers should continue to review how they make best use of assessment information to directly influence teaching and learning. This will help ensure that all children experience appropriate pace and challenge in their learning.

- Staff support each other very well. They also work effectively with colleagues from other schools. This includes opportunities to engage in a range of moderation activities.

- The Head Teacher uses a whole school tracking system to monitor effectively children's progress and attainment in literacy, numeracy and health and wellbeing. Staff use this data well to support their termly discussions about the progress of all children. Staff use tracking data to measure the impact of interventions and to inform improvement priorities.

Quality of provision of Special Unit (contributes to school evaluations)

- Children across both provisions benefit from positive and nurturing relationships with staff. Staff understand well the range of children's individual needs. Most children engage appropriately in learning activities, behave well and demonstrate good levels of concentration. A few children disengage from learning at times as a result of their additional support needs. Staff support children well when they are distressed and use agreed strategies to help children reengage in their learning.

- Children in the specialist provision are developing appropriate opportunities to develop independence through the use of visual supports and individual timetables. These are helping them understand their daily routines. In a few classes, teachers need to organise transitions better and this should avoid children becoming disengaged. A few children need to be more challenged in their learning with activities that take greater account of their ability.

- Children in the enhanced provision engage well in tasks and activities. They interact appropriately with each other and show good levels of social interaction with peers in their learning and play. Staff should increase the pace of learning for the majority of children. A few children would benefit from better play-based learning to support their literacy and numeracy skills.

- Children have plentiful opportunities to learn within the local and wider community. Staff plan activities that offer learning opportunities in a range of contexts such as shops, cafes and libraries.

- Planning, tracking and monitoring approaches take appropriate account of children's different levels of communication, strengths and needs. Support staff and teachers work well together to ensure that evidence of progress and achievement is recognised and recorded. Teachers should take a more dynamic approach to planning to take account of children's progress.

- Teachers use learner journals to provide a good record of the progress children are making and achievement of targets. Staff should continue to ensure narratives in journals provide clear evaluations of learning and progress.

QI 3.2 – Raising attainment and achievement

Attainment in literacy and numeracy

- Overall, attainment in literacy and numeracy is good. Attainment data indicates that most children are on track to achieve expected Curriculum for Excellence levels in literacy and numeracy. At key reporting stages, there are a few children who are exceeding expected levels of attainment. Most children who require additional support for their learning are making good progress towards their individual targets.

Attainment over time

- Senior leaders have reviewed and strengthened their approaches to gathering and analysing data on children's attainment. They have increased assessment and moderation approaches across the school to ensure teachers have a clearer understanding of children's progress across and within levels. As a result, most children continue to make good progress in their learning over time.

- Staff track children's progress in literacy, numeracy and health and wellbeing regularly. Overall, most children make good progress as they move through the school. Staff have employed a range of interventions to raise attainment in literacy and numeracy for children impacted by poverty. These are having a positive impact on children's attainment in reading and numeracy.

- Senior leaders monitor children's attendance carefully. They identify children who have challenges in sustaining regular attendance. They work closely with families to reduce absences. Senior leaders follow the local authority policy and use the School and Family Development Worker to help improve individual children's attendance. Children supported through this intervention have improved their attendance. Senior leaders report that the most effective strategy to improve children's attendance has been to develop positive and trusting relationships with families. Attendance is in line with the national average.

Overall quality of learners' achievements

- Staff and children celebrate children's achievements well across the school through assemblies, house points and the 'Wider Achievement' wall. Almost all

children engage positively with pupil leadership groups. Children are developing as successful and confident individuals, contributing to the life of the school as a result of their participation in these groups.

- The school has strong partnership working with local charity and business organisations which is leading to better outcomes for children, particularly within health and wellbeing. Children speak positively about their school's approach to ensuring they lead a healthy and active lifestyle. Senior leaders and staff are responsive to children's interests and create clubs to meet their needs. They have a sound understanding of individual circumstances and take steps to support children at risk of missing opportunities. As a next step, staff should support children to identify, share and track the skills they are developing through participation in these activities.

Equity for all learners

- All staff understand the socio-economic background of children and their families and the context of the school. Senior leaders and teachers monitor the progress of individuals and groups of children. This includes children who require additional support, are care experienced, or face poverty-related barriers to their learning and wellbeing. Most identified children continue to make progress against their individual targets.

- Staff have taken positive action to address the cost of the school day to ensure that finance is not a barrier to children's participation in the life of the school. They are sensitive to the increasing financial pressures on children and their families.

- The Head Teacher has allocated Pupil Equity Fund (PEF) effectively to provide a range of universal and targeted interventions to support improved outcomes for children across the school. Senior leaders should continue to monitor the impact of all initiatives on outcomes for children. This should help to ensure continued progress towards closing the poverty related attainment gap and accelerating progress for learners.

Quality of provision of Special Unit (contributes to school evaluations)

- The majority of children are making good progress in their learning. With more individualised planning and more challenging learning, there are opportunities for a few children to make even better progress, particularly in numeracy and mathematics

- Children are developing good communication skills. Children use visual symbols and objects of reference well to understand their routines and activities. Staff should now support children to continue to develop communication skills to make choices and give their views

- Children are developing important life skills through learning in the local and wider community. Children visit local cafés, parks, libraries and shops. As a result, they demonstrate good social and communication skills in these different contexts. Children are able to transfer these skills to situations at home with their families. Parents are very positive about how this meaningful learning in different contexts impacts positively on family life.

- Children are developing a good understanding of number. Staff should now ensure children develop skills in numeracy and maths that are better matched to their individual strengths and abilities. This will support children to make better progress in this area.

- Children in the enhanced provision attend weekly assemblies with mainstream peers and enjoy opportunities to celebrate their achievements. Children's achievements are shared with parents through the use of an online application. Parents are very positive about the information they receive about their child's progress and achievements.

- Staff across both provisions understand the strengths and challenges faced by children and their families. They have created an inclusive ethos that promotes equity. Staff place an importance on helping children receive positive educational experiences and equity in learning.

Key activity to date has included the following:

- The Head Teacher has led a whole staff development session to ensure full understanding of the inspection findings, including strengths and identified areas for improvement.
- School staff will continue with planned improvement activities for the remainder of this school session as agreed by HM Inspectors and as a result the School Improvement Plan has been adapted accordingly.

Full details of the Summary of Inspection Findings are available at St Fergus' RC Primary School | Inspection Report | Education Scotland

Explanation of terms of quantity

The following standard Education Scotland terms of quantity are used in this report:

All	100%
Almost all	91-99%
Most	75%-90%
Majority	50-74%
Minority/less than half	15%-49%
A few	less than 15%

Audrey May
Executive Director

Paul Fleming
Chief Education Officer

Signed

Audrey May, Executive Director of Children and Families Service

Paul Fleming, Head of Service (Chief Education Officer)

ITEM No …3……..

REPORT TO: **SCRUTINY COMMITTEE – 23 APRIL 2025**

REPORT ON: **INSPECTION REPORT ON FOSTERING AND ADOPTION SERVICE**

REPORT BY: **EXECUTIVE DIRECTOR OF CHILDREN AND FAMILIES SERVICE**

REPORT NO: **136 - 2025**

1.0 PURPOSE OF REPORT

1.1 This report provides a summary of the Care Inspectorate inspection of the Children and Families Service Fostering, Adoption and Continuing Care Service published in December 2024 and January 2025 (Appendix 1).

1.2 The inspection was a follow-up to a previous inspection published in December 2022 and covered the same 3 categories of How Well We Support People's Wellbeing, How Good is Our Care and Support Planned and How Good is Our Leadership.

1.3 The Fostering, Adoption and Continuing Care Service improved in all 3 categories of inspection, with Adoption and Continuing Care moving from Adequate to Very Good in 2 categories. All 3 requirements and 4 of the 5 areas for improvement from the last inspection were met.

2.0 RECOMMENDATION

2.1 It is recommended that the Committee:

a Note the content of this report, including significant progress made since the last inspection in all 3 categories and the recent implementation of the requirement and area for improvement within the stipulated timescale of 30 March 2025.

b Request the Executive Director to ensure that all other areas for improvement are acted on and provide routine updates as part of the service's annual report on Our Promise to Care Experienced Children, Young People and Care Leavers 2023-26.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 BACKGROUND

4.1 The Children and Families Service has two teams which assess and provide support to all interim foster carers, long term and permanent foster carers and adoptive parents, including reports and recommendations to Fostering and Adoption Panels.

4.2 The teams therefore provide support to a wide range of fostering and adoptive care arrangements for children and young people aged between 0-21 years, including those in Continuing Care.

4.3 The Fostering and Adoption Panel system forms part of the service as a statutory function which registers or de-registers prospective foster carers and approves permanence plans and adopters for children and young people.

4.4 The December 2022 inspection was carried out whilst the service also commissioned an external review of the team's practice by the Association of Fostering Kinship and Adoption (AFKA) to inform the development of a required Improvement Plan.

4.5 The external inspection and internally commissioned review arrived at similar findings, including 3 requirements and 5 areas for improvement. This has informed the development and close senior management oversight of an Improvement Plan implemented over the last 18 months.

5.0 METHODOLOGY AND KEY FINDINGS

Table 1 Improvement in Inspection Grades from 2022 to 2025

Category of Inspection	Fostering (2022 and 2025)	Continuing Care (2022 and 2025)	Adoption (2022 and 2025)
How well we support people's wellbeing	Adequate to Very Good	Adequate to Very Good	Adequate to Good
How good is our care and support planned	Adequate to Very Good	Adequate to Very Good	Adequate to Good
How good is our leadership	Weak to Adequate	Weak to Adequate	Weak to Adequate

5.1 The recent inspection was carried out from October to November 2024 and involved reference to policies and procedures, case file audits and interviews with the teams, other professionals, carers and children. Grades improved in all categories as demonstrated in Table 1. Key messages include:

- Children and young people experienced supportive, nurturing and enduring relationships with caregiver families, providing them with a sense of belonging.
- Children had a strong sense of their family identity and meaningful family connections were maintained - this was an area of strength.
- Caregivers valued staff skills and knowledge, felt very well supported by their supervising social worker and noted that staff were skilled at supporting them.
- Children and young people's contribution to care planning was evident and young people understood their plans.
- Plans for young people were holistic-specific, measurable, achievable, relevant and time-bound. Young people were involved in their plans and understood them.
- Young people enjoyed warm, affectionate, and trusting relationships with their caregivers promoting a sense of belonging and security.
- Carers were strong advocates for young people and took a rights-based approach, ensuring that the right services and supports were made available when needed.
- Caregivers were supportive of the young people attaining well in school and in some cases worked closely alongside the birth family to ensure that this was the case.
- Where possible young people lived with their siblings, where this was not possible there was a focus on maintaining these relationships.
- Caregivers were supported to help young people understand their history. We saw good use of memory boxes and the introduction of monthly letters to young people.
- Young people experienced supportive, enduring relationships with fostering families beyond the age of 18 that provided them with a sense of belonging.

5.2 All 3 requirements from the last inspection of risk assessment policies and training; case records and quality assurance; and care planning were met. Four of 5 areas for improvement on assessment matching; life story work; training to families; and participation were also met.

5.3 The area for improvement which was not met involved the functioning, membership and training of the panel. It had been anticipated and explained the more moderate improvement in the category of Leadership. It was included in the inspection as a requirement.

5.4 However, the inspectors noted a clear 'culture of ambition and celebrating success led by staff and carers' whilst also confirming some continued areas for improvement, each of which had been recognised by the service in advance.

6.0 AREAS FOR IMPROVEMENT

6.1 The inspection outlined one requirement and one area for improvement, with the Fostering and Adoption Panel the key focus. Inspectors noted that the panel functioned well in terms of decision-making but the previous area for improvement on training had not been met.

6.2 The service had been aware of this, and it had occurred due to challenges in recruiting to a vacant post, which created 'a sense of uncertainty' over the roles of panel members. In response and as a summary of actions taken since the inspection.

7.0 REQUIREMENT

7.1 By 30 March 2025, to ensure effectiveness of decision making at the Fostering and Adoption Panels, the provider must ensure clear oversight of panel functioning and membership. To do this the provider must as a minimum:

a) ensure that roles associated with panel membership and function are explicit,
b) ensure a diverse panel membership with appropriate level of independence,
c) ensure panel members receive adequate training and annual appraisals.

7.2 A Senior Officer (Fostering, Adoption, Permanence and Kinship Service) came into post in November 2024. The functions of the post include recruitment, support, training and annual appraisals of panel members.

7.3 Since starting, several Panel Business Meetings and development sessions have been convened; a training calendar for panel members has been approved with input from Medical Advisors and AFKA; and annual appraisals were completed in March 2025.

7.4 To promote a diversity of panel membership, including varying experience, knowledge and skills, the Senior Officer has also expanded the recruitment programme to include health and education professionals.

7.5 The Senior Officer has developed a quality assurance template to facilitate a process for gathering feedback on panels, provide an overview of the panel functioning and continue to jointly identify areas for improvement and/or additional support.

8.0 AREAS FOR IMPROVEMENT

8.1 To ensure families are best supported within the appropriate regulations, the service should ensure that all dual registered foster carer/adopters are supported in line with fostering legislation and best practice. This includes, but is not limited to, ensuring systems are in place for identification and panel review of dual registered prospective adopters.

8.2 As noted in the inspection report, plans were already implemented to address this area for improvement during the inspection period. It relates to carers who are dual approved as both Foster Carers and Adopters needing to be reviewed annually and not biennially.

8.3 As such, dual-approved foster carer/adopters are now all reviewed annually and the practice of the Adoption Service and the Fostering, Adoption and Permanence Panel in line with fostering legislation.

9.0 CONCLUSION

9.1 The Care Inspectorate inspection published in December 2022 occurred while the service commissioned an external AFKA review and arrived at similar findings, which have led to the development and implementation of a comprehensive Improvement Plans.

9.2 As a result, clear progress has been made in all 3 categories of inspection and both the recent requirement and area for improvement have already been addressed within the timescale of 30 March 2025.

10.0 POLICY IMPLICATIONS

10.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

11.0 CONSULTATIONS

11.1 The Council Leadership Team have been consulted in the preparation of this report and are in agreement with its content.

12.0 BACKGROUND PAPERS

12.1 None.

Audrey May
Executive Director
Children and Families Service
Dundee City Council

Glyn Lloyd
Head of Children Services and Community Justice
Chief Social Work Officer
Dundee City Council

MARCH 2025

APPENDIX 1

Dundee City Council - Fostering Service
Fostering Service

5 city square
Dundee
DD1 3BA

Telephone: 01382 436 000

Type of inspection:
Announced (short notice)

Completed on:
21 November 2024

Service provided by:
Dundee City Council

Service provider number:
SP2003004034

Service no:
CS2005097782

About the service

Dundee City Council provides a Fostering, Adoption and Adult Placement service for children and young people who are assessed as in need of alternative family care.

The agency recruits and supports caregiver families to provide a range of alternative care arrangements for children and young people, including, emergency, interim, long term, permanent and short breaks. Both the fostering and adoption team support caregivers and children and young people in permanency planning and adult placement (continuing care), and the findings and key messages in this report are relevant to both teams.

A registered Adult Placement (Continuing Care) service is linked to the Fostering Service. This enables young people to remain in their family home beyond the age of 18 years, with continued support from the service. The service aims to recruit, assess, train and support caregivers from a range of backgrounds with different skills and experiences to help meet the individual needs and improve outcomes for all care experienced children and young people living in approved caregiver households, within the city. The service aims to increase and sustain the number of caregiver families to ensure that children and young people, who are
unable to live with their birth family, can access alternative caregiver families who are able to meet their needs.

As the findings in this inspection are based on a sample of children and young people, inspectors cannot assure the quality of experience for every single child receiving a service.
Inspections of the Continuing Care and Adoption services have been undertaken and separate reports have been completed.

Dundee City Council Fostering Service has been registered with the Care Inspectorate since the Care Inspectorate was formed in 2011.

About the inspection

This was a short announced inspection which took place between 28 October and 20 November 2024. The inspection was carried out by two inspectors from the Care Inspectorate.

To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- Spoke with three caregiver foster families, eight staff and management.
- We observed practice and daily life, reviewed documents.
- Spoke with relevant professionals.

Key messages

- Children and young people experienced supportive, nurturing and enduring relationships with caregiver families, providing them with a sense of belonging.
- Children had a strong sense of their family identity and meaningful family connections were maintained this was an area of strength.
- A requirement was made in relation to the Fostering and Adoption Panel to ensure overview of the effectiveness of its functioning and membership.
- Caregivers valued staff skills and knowledge and felt very well supported by their supervising social worker.
- Children and young people's contribution to care planning was evident, young people understood their plans.
- Plans for young people were holistic specific, measurable, achievable, relevant and time-bound.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	5 - Very Good
How good is our leadership?	3 - Adequate
How well is our care and support planned?	5 - Very Good

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 5 - Very Good

We found significant strengths in aspects of the care provided and how these supported positive outcomes for children and their families, therefore we evaluated this key question as very good.

Quality Indicator: 1.1 Children, young people, adults and their caregiver families experience compassion, dignity and respect.
Quality Indicator: 1.2 Children, young people and adults get the most out of life.
Quality Indicator: 1.3 Children, young people and adults' health and wellbeing benefits from the care and support they experience.
Quality Indicator: 1.4 Children, young people, adults and their caregiver families get the service that is right for them.

Young people had developed meaningful affectionate, secure relationships with their carers. Relationships were based on love, compassion and empathy. As a result children were thriving.
Carers were very positive about the high quality and responsive support they received from their supervising social workers and the wider service. They were confident that they were receiving appropriate training.

We saw that there was reflective discussion carried out with carers during supervision visits. Carers told us that they had regular visits from social work and were able to get support as and when they needed. Carers were trauma informed, this was evident in the sensitive response care provided.

Support groups were available to carers. We observed one such group, this was well organised and demonstrated a good balance of informal meetings and some structured learning. Carers valued these groups.

Young people were involved in decisions about their care in ways that were meaningful to them. Caregivers and birth families were recognised and significant persons in the decision-making process. The views of all were listened too and respected, this was an area of strength.

Young people were able to spend regular time away from care giver families. Short break services were available and planned. Natural family supports were also used and were particularly effective for young people requiring additional supports.

All the young people were able to exercise a high degree of choice that was age appropriate. Care provision was personalised and provided by carers that understood the needs and preferences of the young people in their care. This contributed to positive outcomes and experiences for children.

Maintaining relationships with birth families was encouraged and promoted and was an area of strength. Where possible young people lived with their siblings, where this was not possible there was a focus on maintaining these relationships.

Care givers were supportive of the young people attaining in school and in some cases worked closely alongside the birth family to ensure that this was the case. There was a culture of ambition, and all achievements were recognised and celebrated.

We saw that caregivers' learning was now a priority and this was welcomed by the carers. Carers were able to speak with great insight of the impact of Trauma and adverse childhood experiences (ACE's.) on the young people. Caregivers were engaged in their own learning and development. A range of available training enhanced caregivers' skills and knowledge and the service responded creatively to individual training needs and circumstances.

Children were supported to thrive, and develop a strong sense of identity and positive mental health. This was supported by nurturing and predictable relationships with carers. These relationships were supported by workers within the fostering service, who helped carers to make sense of children's needs and presenting behaviours, and respond to these in a loving and supportive way.

Children who had varied and complex health needs received a high level of care in response to their individual health needs through multi-agency working between caregivers, agencies and birth families.

Caregivers were supported to help young people understand their history. We saw good use of memory boxes and the introduction of monthly letters to the young people.

Young people received consistent, nurturing care from trauma informed carers that worked sensitively and creatively with young people to understand their life story.

Caregivers experienced positive and established relationships with their supervising social workers and greatly valued staff knowledge, skills, commitment, and responsiveness. Care givers told us they felt supported and listened to by their social workers and that any and all concerns were responded too promptly in an inclusive supportive manner.

Care givers promoted healthy active lifestyles supporting young people to make healthy choices, appropriate daily routines and structures were evident to support physical and emotional wellbeing.

Carer assessments were comprehensive ensuring that they had the capacity, skills and knowledge to meet the needs of children and young people. The quality of assessment presented at review panels was high, covering all key areas and providing an assessment of carer competencies, strengths and potential vulnerabilities.

Matching decisions were robust with the needs of the young person and the capacity of the carers to meet this closely considered. The strengths and vulnerabilities of the carers were carefully considered by a team that knew their carers well. Consideration of the impact of other young people already living in the family home was also evident. We saw evidence of some very effective transition work where the birth family was closely involved.

In the families we tracked we saw that decisions were made around permanence without unnecessary delay.

How good is our leadership? 3 - Adequate

An evaluation of adequate has been award to this key question. A number of strengths were identified in the service which just outweighed the weaknesses identified.

Quality Indicator: 2.2 Quality assurance and improvement are led well

Quality assurance processes were robust and effective in supporting continuous improvement. Systems for tracking children's journeys were well managed which resulted in children achieving stability from permanent care without delay. Management of risk was significantly improved since the last inspection with processes being fully implemented. There was a high level of oversight on the functioning of the service from the manager and senior management which was supported by clear development plans.

Staff were well supported with formal supervision. This resulted in a staff team being valued in their work and a greater morale within the team. There had been changes within leadership but there had been a good level of communication which supported the change. One staff member told us, "team morale is very good with excellent direct line supervision and management of casework."

There was some uncertainty within the team that current or predicted vacancies would be recruited to. There should be timely recruitment to ensure limited impact on service delivery.

The Fostering and Adoption Panels functioned well in terms of decision making and exploration of relevant issues. However, some roles within the panel membership lacked clarity. There was no process for gathering feedback in relation to panels and limited overview of the panel functioning.

In addition, the panel would benefit from greater diversity and independence within the panel membership. At the last inspection, an area for improvement was made in relation to support and training for all panel members which we have concluded had not been met at this inspection. There was a sense of uncertainty around the panel and without addressing those issues the effectiveness of its function would be quickly undermined. (See Requirement 1).

Requirements

1. By 30 March 2025, to ensure effectiveness of decision making at the Fostering and Adoption Panels, the provider must ensure clear oversight of panel functioning and membership. To do this the provider must as a minimum:

a) ensure that roles associated with panel membership and function are explicit,

b) ensure a diverse panel membership with appropriate level of independence,

c) ensure panel members receive adequate training and annual appraisals.

This is to comply with Regulation 4(1)(a) and (d) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210). This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I experience high quality care and support based on relevant evidence, guidance and best practice" (HSCS 4.11).

How well is our care and support planned? 5 - Very Good

We found important strengths in supporting outcomes for young people. There are very few areas for improvement and those that do exist will have a minimal impact on people's experiences and outcomes. Therefore, we evaluated this key question as very good.

Quality Indicator: 5.1 Assessment and care planning reflects the outcomes and wishes of children, young people and adults

Young people led healthy meaningful lives because of plans that were detailed and Specific Measurable, Achievable, Realistic and Timely (SMART). These plans reflected the wishes and needs of young people and their foster families. Young people and their families were at the centre of support planning. A parent told us 'they listen and talk to him if he wants something they try to make it happen, everyone is involved.'

Children's plans were reviewed within appropriate timescales and the quality of these plans were consistently good. Families were confident that they knew what the care plans were for their children. All relevant persons were included in planning and linking meetings.

Young people had access to advocacy, we saw that the carers and service advocated strongly on their behalf. Birth families were actively involved and had forged positive relationships with carers ensuring the rights of the young people were championed.

Outcomes for young people were supported by high quality multi-agency planning and individual safer care approaches. Assessments of need and risk were robust and regularly reviewed.

The service was proactive and aspirational. A multi-agency approach was evident throughout the planning process ensuring that all young people had appropriate effective plans in place. Young people's records and plans were of a consistently high standard.

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 1

By 28th February 2023, to ensure the safety and wellbeing of children and young people and the provision of high-quality care and support, the provider must ensure risks are recognised, identified and effective mechanisms are in place to manage and report risks. To do this, the provider must, as a minimum:

a) Provide child and adult protection training to caregiver families and staff.

b) Ensure risk assessment policies and procedures provide clear guidance and risk assessment documentation, for identifying, reporting and managing risks.

c) Develop a robust and responsive system to monitor and review risks.

This is to comply with Regulation 4(1)(a) (Welfare of Users) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) and to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes' (HSCS 3.14) and 'I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities' (HSCS 3.20).

This requirement was made on 19 November 2022.

Action taken on previous requirement

We have assessed that a robust training programme has been implemented with child and adult protection training being mandatory for all carers. We found good recording of incidents along with analysis and appropriate response. There were discussions during inspection regarding notifications and have confidence that this process is now fully understood and will be embedded into practice. The implementation of the policies and procedures have resulted in more confidence within the services to respond to risk appropriately. All staff had attended training on protection and risk management since the last inspection

Met - outwith timescales

Requirement 2

By 28th February 2023, to ensure quality care and support is received by all children, young people and their families, the provider must develop a culture of continuous improvement by implementing robust quality assurance of practice. To do this, the provider must as a minimum:

a) Ensure that records and practices are in place to evidence the effectiveness of the service in meeting the needs of young people.

b) Ensure a robust audit system is in place and promote a shared responsibility in quality assurance processes to identify area for improvement.

This is to comply with Regulation 4(1)(a) (Welfare of Users) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) and to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (4.19) and 'I use a service and organisation that are well led and managed' (4.23).

This requirement was made on 19 November 2022.

Action taken on previous requirement

We have assessed that the current quality assurance systems and practice is adequate to have met this requirement. Some of the systems reviewed were robust and effective to review the service capacity to meet the needs of children and young people. However, we also recognised that some of the systems needed continued focus.

Met - outwith timescales

Requirement 3

By 28th February 2023, the provider should ensure that adoption support planning documentation for children and young people takes a SMART approach (specific, measurable, achievable, relevant and time- bound). To do this the provider must, as a minimum, ensure:

a) Assessed needs are accompanied with detailed action points.
b) Professional involvement to support progression of action points is clearly recorded.
c) Delay and drift in progressing action points are addressed and recorded.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210) and to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My personal plan (sometimes referred to as my care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (HSCS 1.15) and 'I experience high quality care and support based on relevant evidence, guidance and best practice' (HSCS 4.11).

This requirement was made on 19 November 2022.

Action taken on previous requirement
A similar requirement was made for the adoption and fostering services. While we acknowledge that the court process has delayed plans for children in some cases, this was outwith of the control of the services.

Met - outwith timescales

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

To enable thorough caregiver assessment and matching the needs of children with a family's strengths and vulnerabilities, a review of the process of assessment should be undertaken. This should include, but not be limited to, training to all staff within the service.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'My care and support meets my needs and is right for me' (HSCS 1.19); and
'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes.' (HSCS 3.14).

This area for improvement was made on 19 November 2022.

Action taken since then
Although we did not see evidence of specific training in assessment being offered to staff, we did see significant improvement to the quality assessments completed of caregiving families. This Area for Improvement has been Met.

Previous area for improvement 2

To ensure all children have a clear understanding of their past the provider should improve its approach to life story work. This should include, but is not limited to, implementing a consistent approach to gathering and storing important life story information and providing specific training to staff and caregivers about how life story work should be approached.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I am supported to be emotionally resilient, have a strong sense of my own identity and wellbeing, and address any experiences of trauma or neglect.' (HSCS 1.29).

This area for improvement was made on 19 November 2022.

Action taken since then
Clear evidence of Memory boxes being used to good effect, carers recognising the importance of LSW (Life Story Work) and the introduction of Monthly letter to the young people. This Area for Improvement has been Met.

Previous area for improvement 3

To enable caregiver families to fully support the needs of children in their care, the provider should improve availability of training to all families. This should include, but not be limited to, trauma informed practice and attachment training.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I experience high quality care and support based on relevant evidence, guidance and best practice.' (HSCS 4.11).

This area for improvement was made on 19 November 2022.

Action taken since then

The carer training calendar had been reviewed and included a wide range of training available to foster carers and adopters. These included training topics delivered internally as well as by external providers which would support caregiving families to meet the needs of the children in their care. Child protection, adult protection and trauma informed training was mandatory for all foster carers to attend.

We saw evidence that carers had received relevant training in Adult and Child Protection and trauma training. We saw good consistent evidence of young people having a voice throughout. This Area for Improvement has been Met.

Previous area for improvement 4

To ensure children and young people have opportunities and benefit from participation in decisions that affect them, the provider must evidence support provided to children and young people to express their views, attend meetings and understand how their needs will be met through care planning processes.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I am fully involved in developing and reviewing my personal plan, which is always available to me' (HSCS 2.17); and 'My human rights are central to the organisations that support and care for me' (HSCS 4.1).

This area for improvement was made on 19 November 2022.

Action taken since then

Good consistent evidence of young people having a voice throughout. This Area for Improvement has been Met.

Previous area for improvement 5

To enable the panel members to make informed and balanced decisions in the welfare of children, young people and their families, the provider should ensure suitable training and support is available to all panel members.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I use a service and organisation that are well led and managed' (HSCS 4.23).

This area for improvement was made on 19 November 2022.

Action taken since then

Current panel members did not all report having received suitable training to support their role. Of those we spoke to, not all panel members had received an annual appraisal. This Area for Improvement is Not Met.

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support people's wellbeing?	5 - Very Good
1.1 Children, young people. adults and their caregiver families experience compassion, dignity and respect	5 - Very Good
1.2 Children, young people and adults get the most out of life	5 - Very Good
1.3 Children, young people and adults' health and wellbeing benefits from the care and support they experience	5 - Very Good
1.4 Children, young people, adults and their caregiver families get the service that is right for them	5 - Very Good

How good is our leadership?	3 - Adequate
2.2 Quality assurance and improvement are led well	3 - Adequate

How well is our care and support planned?	5 - Very Good
5.1 Assessment and care planning reflects the outcomes and wishes of children, young people and adults	5 - Very Good

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APPENDIX 2

Dundee City Council - Adoption Service
Adoption Service

5 City Square
Floor 2
Dundee
DD1 3BA

Telephone: 01382 43600

Type of inspection:
Announced (short notice)

Completed on:
21 November 2024

Service provided by:
Dundee City Council

Service provider number:
SP2003004034

Service no:
CS2004082550

About the service

Dundee City Council provides a Fostering, Adoption and Adult Placement service for children and young people who are assessed as in need of alternative family care.

The functions of an adoption service are detailed in the Adoption and Children (Scotland) Act 2007 as being to:

- assess children who may be adopted
- assess prospective adopters
- place children for adoption
- provide information about adoption and
- provide adoption support services.

Social workers in the area teams and in the permanence team have responsibility for assessing children's needs for adoption and share responsibility for placing children for adoption. The family placement team carry out the remaining duties of the Local Authority Adoption Agency.

About the inspection

This was a short announced inspection which took place between 28 October and 20 November 2024. The inspection was carried out by two inspectors from the Care Inspectorate.

To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- spoke with three adoptive families
- spoke with eight staff and management
- observed practice and daily life
- reviewed documents
- spoke with two visiting professionals.

The provider of this service is a corporate parent, with statutory responsibilities to look after and accommodate children. This may mean that the duty to care for children and young people on an emergency basis, or with highly complex needs, is their highest safeguarding priority.
In these circumstances our expectations, focus on outcomes and evaluations remain identical to those of all other providers. We may, however, provide some additional narrative in the body of the report to reflect the impact of these duties, should it be relevant to this particular service.

During our inspection year 2024-2025 we are inspecting against a focus area which looks at how regulated services use legislation and guidance to promote children's right to continuing care and how children and young people are being helped to understand what their right to continuing care means for them. Any areas for improvement will be highlighted in this report.

Key messages

Children received nurturing and compassionate care from trauma informed adopters.

Children had a strong sense of their family identity and meaningful connections were strongly promoted.

Dual approval processes supported timely transitions for children, however the service should ensure to follow all procedures within regulations.

A requirement was made in relation to the Fostering and Adoption Panel to ensure overview of the effectiveness of its functioning and membership.

Adoption Support Plans were reviewed as being SMART (specific, measurable, achievable, relevant and time bound) and clearly represented the support being offered from the service.

The service would benefit from greater consistency of recording across the service in relation to safercaring and assessment visits.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	4 - Good
How good is our leadership?	3 - Adequate
How well is our care and support planned?	4 - Good

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 4 - Good

An evaluation of good has been awarded to this key question as a number of strengths were identified which clearly outweighed areas for improvement.

Children experienced compassionate and loving care from their adopters and prospective adopters. Children experienced a sense of being claimed within their adoptive families with strong connections to their caregivers as well as to their extended families. There was a good understanding of trauma and attachment with the result that children experienced a trauma informed approach to their care. Adopters had a high understanding of a child's behaviour as being a form of communication. Children experienced respectful care where their individual strengths and vulnerabilities were acknowledged and supported to ensure the

child would thrive. There was a high level of consistency for the children within adoptive families and limited moves prior to them joining the family.

Prospective adopters had an empathic approach to birth family members and family time. Where relationships were not entirely positive, prospective adopters were considered and mindful in their communication with and about them. This was reflective of the values from the service which emphasised the importance of meaningful connection. Letter box contact was managed well. A contract was completed to be clear on expectations of all parties which was helpful for adopters to understand their commitment to this. Brothers and sisters were supported to remain together. Where this was not possible, ongoing connection was promoted where this was in the best of interest of all children.

Assessment of risk were timely and identified all concerns which resulted in children being kept safe. Staff had knowledge of best practice in relation to risk were confident in their assessment and in the procedures to follow in relation to risk. Not all notifiable events had been reported within timescales however this was rectified during the inspection and will be embedded into practice.

A robust training calendar for foster carers was also available to adopters to support their knowledge and understanding. The training strongly promoted attachment and trauma informed care. The training, support groups and individual support was of a high quality. One adopter telling us "I have been supported extremely well by all workers involved in my child's care, and have always felt valued and listened to".

Children were supported in their mental health and wellbeing. Lifestory was strongly promoted in the service with a high level of importance placed on this. Information was shared timely with all children receiving a lifestory book and later life letter at the point that an adoption order is granted. Lifestory training was provided to caregiving families which resulted in a high understanding for families of the importance.

Assessments were completed to a good standard with a good level of analysis. The views of existing children within the family were central to assessments which felt supportive to them and to their family.

Permanency processes were well supported by the service. Matching processes were clear and decisions were informed by clear assessments of strengths and vulnerabilities. Coordination's and transitions were managed well and at a pace led by the child.

Some families were dual approved as foster carers and adopters in order to support timely transitions for children to their forever family. This was a positive practice and experience for the children as well as their care givers and contributed to good outcomes. While there was recognition that the purpose of the placement was adoption, the service were clear that the legal position was fostering until the adoption order was granted. Fostering processes were followed in the main however reviews had been undertaken in line with adoption agency guidelines and not fostering regulations. The service were swift to respond to this, with plans being implemented to address. No negative outcomes were identified however it is important that regulations are fully followed. (See Area for Improvement 1).

Adoptive and dual approved families were not always clear on the expectations or permissions in relation to care agreements. Families also were not clear on what level of support was available to them post adoption order, or how long this would be available therefore the service should improve the communication to families in relation to this.

Areas for improvement

1. To ensure families are best supported within the appropriate regulations, the service should ensure that all dual registered foster carer/adopters are supported in line with fostering legislation and best practice. This includes, but is not limited to, ensuring systems are in place for identification and panel review of dual registered prospective adopters.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I experience high quality care and support based on relevant evidence, guidance and best practice'. (HSCS 4.11)

How good is our leadership? 3 - Adequate

An evaluation of adequate has been award to this key question. A number of strengths were identified in the service which just outweighed the weaknesses identified.

Quality assurance processes were robust and effective in supporting continuous improvement. Systems for tracking children's journeys were well managed which resulted in children achieving stability from permanent care without delay. Management of risk was significantly improved since the last inspection with processes being fully implemented. There was a high level of oversight on the functioning of the service from the manager and senior management which was supported by clear development plans.

Staff were well supported with formal supervision. This resulted in a staff team being valued in their work and a greater morale within the team. There had been changes within leadership but there had been a good level of communication which supported the change. One staff member told us, "team morale is very good with excellent direct line supervision and management of casework."

There was some uncertainty within the team that current or predicted vacancies would be recruited to. There should be timely recruitment to ensure limited impact on service delivery.

The Fostering and Adoption Panels functioned well in terms of decision making and exploration of relevant issues. However, some roles within the panel membership lacked clarity. There was no process for gathering feedback in relation to panels and limited overview of the panel functioning. In addition, the panel would benefit from greater diversity and independence within the panel membership. At the last inspection, an area for improvement was made in relation to support and training for all panel members which we have concluded had not been met at this inspection. There was a sense of uncertainty around the panel and without addressing those issues the effectiveness of its function would be quickly undermined. (See Requirement 1).

Requirements

1. By 30 March 2025, to ensure effectiveness of decision making at the Fostering and Adoption Panels, the provider must ensure clear oversight of panel functioning and membership. To do this the provider must as a minimum:

a) ensure that roles associated with panel membership and function are explicit,

b) ensure a diverse panel membership with appropriate level of independence,

c) ensure panel members receive adequate training and annual appraisals.

This is to comply with Regulation 4(1)(a) and (d) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210). This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I experience high quality care and support based on relevant evidence, guidance and best practice" (HSCS 4.11).

How well is our care and support planned? 4 - Good

Key strengths were identified, which clearly outweighed areas to improve therefore an evaluation of good was awarded to this key question.

Strong evidence of good outcomes for children were identified due to the strong knowledge of their caregivers and the professionals working with them. However, this level of knowledge and understanding was not always reflected in the quality of the assessments and plans completed across the services. In reviewing supervision discussions or home visits with families, the level of recording was not consistent. Safercaring plans were completed for all families but for some this was at the point of approval and did not contain details specific to the child placed, for others it had been updated to reflect the specific care needs of the child and was a detailed assessment. A greater consistency across the service was needed to ensure that families receive a consistent high quality of support and recording.

Post adoption support plans completed by the service were of a high quality. Plans had clear actions with expected outcomes. The plans reflected the support which was being offered to families and were SMART (specific, measurable, achievable, relevant and time bound). However, there was no formal review process for adoption support plans and it would be beneficial for the service to consider this. This was a requirement made at the last inspection, which we have assessed as being met at this inspection however progress should continue to enhance the documents and procedures further.

Supervising social workers actively engaged in child reviews and advocated for the children and caregivers. Communication with allocated social workers for the children was proactively promoted which was supporting positive working relationships across services.

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 1

By 28th February 2023, to ensure the safety and wellbeing of children and young people and the provision of high-quality care and support, the provider must ensure risks are recognised, identified and effective mechanisms are in place to manage and report risks. To do this, the provider must, as a minimum:

a) Provide child and adult protection training to caregiver families and staff.

b) Ensure risk assessment policies and procedures provide clear guidance and risk assessment documentation, for identifying, reporting and managing risks.

c) Develop a robust and responsive system to monitor and review risks.

This is to comply with Regulation 4(1)(a) (Welfare of Users) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) and to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes' (HSCS 3.14) and 'I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities' (HSCS 3.20).

This requirement was made on 18 November 2022.

Action taken on previous requirement

We have assessed that a robust training programme has been implemented with child and adult protection training being mandatory for all carers. We found good recording of incidents along with analysis and appropriate response. There were discussions during inspection regarding notifications and have confidence that this process is now fully understood and will be embedded into practice. The implementation of the policies and procedures have resulted in more confidence within the services to respond to risk appropriately. All staff had attended training on protection and risk management since the last inspection.

Met - outwith timescales

Requirement 2

By 28th February 2023, to ensure quality care and support is received by all children, young people and their families, the provider must develop a culture of continuous improvement by implementing robust quality assurance of practice. To do this, the provider must as a minimum:

a) Ensure that records and practices are in place to evidence the effectiveness of the service in meeting the needs of young people.

b) Ensure a robust audit system is in place and promote a shared responsibility in quality assurance processes to identify area for improvement.

This is to comply with Regulation 4(1)(a) (Welfare of Users) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) and to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (4.19) and 'I use a service and organisation that are well led and managed' (4.23).

This requirement was made on 18 November 2022.

Action taken on previous requirement
We have assessed that the current quality assurance systems and practice is adequate to have met this requirement. Some of the systems reviewed were robust and effective to review the service capacity to meet the needs of children and young people. However, we also recognised that some of the systems needed continued focus.

Met - outwith timescales

Requirement 3

By 28th February 2023, the provider should ensure that adoption support planning documentation for children and young people takes a SMART approach (specific, measurable, achievable, relevant and time-bound). To do this the provider must, as a minimum, ensure:

a) Assessed needs are accompanied with detailed action points.
b) Professional involvement to support progression of action points is clearly recorded.
c) Delay and drift in progressing action points are addressed and recorded.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210) and to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My personal plan (sometimes referred to as my care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (HSCS 1.15) and 'I experience high quality care and support based on relevant evidence, guidance and best practice' (HSCS 4.11).

This requirement was made on 18 November 2022.

Action taken on previous requirement
A similar requirement was made for the adoption and fostering services. While we acknowledge that the court process has delayed plans for children in some cases, this was outwith of the control of the services.

Adoption support plans completed by the adoption service were found to be robust, with measurable expected outcomes and clear review timescales. We reviewed these as being SMART and therefore have assessed that this requirement has been met.

Met - outwith timescales

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

To enable adoptive families to fully support the needs of children in their care, the provider should improve availability of training to all families. This should include, but not be limited to, trauma informed practice

and attachment training.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I experience high quality care and support based on relevant evidence, guidance and best practice' (HSCS 4.11).

This area for improvement was made on 18 November 2022.

Action taken since then

The carer training calendar had been reviewed and included a wide range of training available to foster carers and adopters. These included training topics delivered internally as well as by external providers which would support caregiving families to meet the needs of the children in their care. In addition to this, adoptive families had access to training through Adoption UK. We have assessed that this area for improvement has been met.

Previous area for improvement 2

To enable thorough assessment of adoptive families and timely matching the needs of children with a family's strength and vulnerability, a review of the process of assessment should be undertaken to understand the impact on families. This should include, but not be limited to, training to all staff within the service.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My care and support meetings my needs and is right for me' (1.19) and 'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes' (HSCS 3.14).

This area for improvement was made on 18 November 2022.

Action taken since then

Although we did not see evidence of specific formal training in assessment being offered to staff, we did see significant improvement to the quality completed assessments of caregiving families. Therefore, we have assessed that this area for improvement has been met.

Previous area for improvement 3

To enable the panel members to make informed and balanced decisions in the welfare of children, young people and their families, the provider should ensure suitable training and support is available to all panel members.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I use a service and organisation that are well led and managed' (HSCS 4.23).

This area for improvement was made on 18 November 2022.

Action taken since then

Current panel members did not all reported having received suitable training to support their role. Of those we spoke to, not all panel members had received an annual appraisal. We have assessed that this area for improvement has not been met and will form part of the requirement made as part of this inspection.

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support people's wellbeing?	4 - Good
1.1 Children, young people. adults and their caregiver families experience compassion, dignity and respect	4 - Good
1.2 Children, young people and adults get the most out of life	5 - Very Good
1.3 Children, young people and adults' health and wellbeing benefits from the care and support they experience	5 - Very Good
1.4 Children, young people, adults and their caregiver families get the service that is right for them	4 - Good

How good is our leadership?	3 - Adequate
2.2 Quality assurance and improvement are led well	3 - Adequate

How well is our care and support planned?	4 - Good
5.1 Assessment and care planning reflects the outcomes and wishes of children, young people and adults	4 - Good

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یہ اشاعت درخواست کرنے پر دیگر شکلوں اور دیگر زبانوں میں فراہم کی جاسکتی ہے۔

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Dundee City Council Adult Placement - Continuing Care

Adult Placement Service

Dudhope Castle
Dudhope Park
Barrack Road
Dundee
DD3 6HF

Telephone: 01382 436 004

Type of inspection:
Announced (short notice)

Completed on:
21 November 2024

Service provided by:
Dundee City Council

Service provider number:
SP2003004034

Service no:
CS2019377882

About the service

Dundee City Council provides a Fostering, Adoption and Adult Placement service for children and young people who are assessed as in need of alternative family care.

The agency recruits and supports caregiver families to provide a range of alternative care arrangements for children and young people, including, emergency, interim, long term, permanent and short breaks. Both the fostering and adoption team support caregivers and children and young people in permanency planning and adult placement (continuing care), and the findings and key messages in this report are relevant to both teams.

A registered Adult Placement (Continuing Care) service is linked to the Fostering Service. This enables young people to remain in their family home beyond the age of 18 years, with continued support from the service. The service aims to recruit, assess, train and support caregivers from a range of backgrounds with different skills and experiences to help meet the individual needs and improve outcomes for all care experienced children and young people living in approved caregiver households, within the city. The service aims to increase and sustain the number of caregiver families to ensure that children and young people, who are unable to live with their birth family, can access alternative caregiver families who are able to meet their needs.

As the findings in this inspection are based on a sample of children and young people, inspectors cannot assure the quality of experience for every single child receiving a service.
Inspections of the Continuing Care and Adoption services have been undertaken and separate reports have been completed.

Dundee City Council Fostering Service has been registered with the Care Inspectorate since the Care Inspectorate was formed in 2011.

About the inspection

This was a short announced inspection which took place between 28 October and 19 November 2024. The inspection was carried out by two inspectors from the Care Inspectorate.

To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- spoke with carer families
- spoke with eight staff and management
- observed practice and daily life
- reviewed documents
- spoke with two visiting professionals.

The provider of this service is a corporate parent, with statutory responsibilities to look after and accommodate children. This may mean that the duty to care for children and young people on an emergency basis, or with highly complex needs, is their highest safeguarding priority.

In these circumstances our expectations, focus on outcomes and evaluations remain identical to those of all other providers. We may, however, provide some additional narrative in the body of the report to reflect the impact of these duties, should it be relevant to this particular service.

During our inspection year 2024-2025 we are inspecting against a focus area which looks at how regulated services use legislation and guidance to promote children's right to continuing care and how children and young people are being helped to understand what their right to continuing care means for them. Any areas for improvement will be highlighted in this report.

Key messages

- Young people experienced supportive, enduring relationships with fostering families beyond the age of 18 that provided them with a sense of belonging.
- Young people were supported to maintain meaningful relationships with extended family members and were involved in the wider community.
- Caregivers valued relationships with their social workers, and we assessed that staff were skilled at supporting them.
- Young people's plans were up-to-date and regularly reviewed. Young people were involved in their plans and understood them.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	5 - Very Good
How good is our leadership?	3 - Adequate
How well is our care and support planned?	5 - Very Good

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 5 - Very Good

We found significant strengths in aspects of the care provided and how these supported positive outcomes for children and their families, therefore we evaluated this key question as very good.

Quality Indicator: 1.1 Children, young people, adults and their caregiver families experience compassion, dignity and respect.
Quality Indicator: 1.2 Children, young people and adults get he most out of life.
Quality Indicator: 1.3 Children, young people and adults' health and wellbeing benefits from the care and support they experience.
Quality Indicator: 1.4 Children, young people, adults and their caregiver families get the service that is right for them.

Young people enjoyed, warm, affectionate, and trusting relationships with their caregivers promoting a sense of belonging and security. There were good examples of young people's voices being valued by the provider.

Caregivers we spoke to valued staff and carers and told us they received high levels of support from a service which was responsive and adaptive. The relationships between young people, caregivers and staff were robust and positive.

Caregivers and workers ensured young people had a good understanding of their rights under the continuing care legislation and ensured when young people were making choices they were supported to do so in planned and consistent way.

Young people were achieving very positive outcomes in education and were fully supported to pursue their personal interests. Young people were supported to have fulfilling lives with high aspirations for success. This supportive and positive culture contributed to positive outcomes for young people.

Positive relationships between young people their carers and the staff group was central to ensuring the stability of care provided. Carers told us that staff were always available offering support and guidance when required. Regular training opportunities and supervision from social work meant that caregivers were knowledgeable and skilled in their approach to caring for young people with a good understanding of Trauma and attachment. This helped young people to feel loved and valued.

Young people were supported to maintain relationships with the people that were important to them. It was evident that young people's choices in this were respected. Young people received care that met their individual needs and kept them emotionally and physically safe.

Carers were strong advocates for the young people and took a rights based approach. Ensuring that the right services and supports were made available when needed. There was a clear culture of ambition and celebrating success which was led by staff and carers.

Staff proactively supported carers through regular visits, frequent communication, and responsive approaches. We saw good evidence of effective collaborative multi-agency working where the needs and wishes of the young people were central.

We saw that young people were fully integrated into carer families, that they were loved and nurtured promoting their self worth and sense of identity.

How good is our leadership? 3 - Adequate

An evaluation of adequate has been award to this key question. A number of strengths were identified in the service which just outweighed the weaknesses identified.

Quality Indicator: 2.2 Quality assurance and improvement are led well

Quality assurance processes were robust and effective in supporting continuous improvement. Systems for tracking children's journeys were well managed which resulted in children achieving stability from permanent care without delay. Management of risk was significantly improved since the last inspection with processes being fully implemented. There was a high level of oversight on the functioning of the service from the manager and senior management which was supported by clear development plans.

Staff were well supported with formal supervision. This resulted in a staff team being valued in their work and a greater morale within the team. There had been changes within leadership but there had been a good level of communication which supported the change. One staff member told us, "team morale is very good with excellent direct line supervision and management of casework."

There was some uncertainty within the team that current or predicted vacancies would be recruited to. There should be timely recruitment to ensure limited impact on service delivery.

The Fostering and Adoption Panels functioned well in terms of decision making and exploration of relevant issues. However, some roles within the panel membership lacked clarity. There was no process for gathering feedback in relation to panels and limited overview of the panel functioning. In addition, the panel would benefit from greater diversity and independence within the panel membership. At the last inspection, an area for improvement was made in relation to support and training for all panel members which we have concluded had not been met at this inspection. There was a sense of uncertainty around the panel and without addressing those issues the effectiveness of its function would be quickly undermined. (See Requirement 1).

Requirements

1. By 30 March 2025, to ensure effectiveness of decision making at the Fostering and Adoption Panels, the provider must ensure clear oversight of panel functioning and membership. To do this the provider must as a minimum:

a) ensure that roles associated with panel membership and function are explicit,

b) ensure a diverse panel membership with appropriate level of independence,

c) ensure panel members receive adequate training and annual appraisals.

This is to comply with Regulation 4(1)(a) and (d) (Welfare of users) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "I experience high quality care and support based on relevant evidence, guidance and best practice" (HSCS 4.11).

How well is our care and support planned? 5 - Very Good

We found important strengths in supporting outcomes for young people. There are very few areas for improvement and those that do exist will have a minimal impact on people's experiences and outcomes. Therefore, we evaluated this key question as very good.

Quality Indicator: 5.1 Assessment and care planning reflects the outcomes and wishes of children, young people and adults

Young people led healthy meaningful lives because of plans that were detailed and Specific Measurable, Achievable, Realistic and Timely (SMART). These plans reflected the wishes and needs of young people and their carer families. Young people and their families were at the centre of support planning.

Young people's plans were consistently reviewed within appropriate timescales and the quality of these plans were good. All relevant persons were included in planning and linking meetings.

Unannounced visits were undertaken and the young people had a pathway plan completed 5th August 2024 and an annual review date set for 2025.

Young people had access to advocacy, we saw that the carers and service advocated strongly on their behalf. Birth families were actively involved and had forged positive relationships with carers ensuring the rights of the young people were championed.

Outcomes for young people were supported by high quality multi-agency planning and individual safer care approaches. Assessments of need and risk were robust and regularly reviewed.

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 1

By 28th February 2023, to ensure the safety and wellbeing of children and young people and the provision of high-quality care and support, the provider must ensure risks are recognised and identified and effective mechanisms are in place to manage and report risks.

To do this, the provider must, as a minimum:
(a) Provide child and adult protection training to caregiver families and staff.
(b) Ensure risk assessment policies and procedures provide clear guidance and risk assessment documentation, for identifying, reporting and managing risks.
(c) Develop a robust and responsive system to monitor and review risks.

This is to comply with Regulation 4(1)(a) (Welfare of Users) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes' (HSCS 3.14); and
'I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities.' (HSCS 3.20).

This requirement was made on 18 November 2022.

Action taken on previous requirement
We have assessed that a robust training programme has been implemented with child and adult protection training being mandatory for all carers.
We found good recording of incidents along with analysis and appropriate response. There were discussions during inspection regarding notifications and have confidence that this process is now fully understood and will be embedded into practice. The implementation of the policies and procedures have resulted in more confidence within the services to respond to risk appropriately. All staff had attended training on protection and risk management since the last inspection.

Met - outwith timescales

Requirement 2

By 28th February 2023, to ensure quality care and support is received by all children, young people and their families, the provider must develop a culture of continuous improvement by implementing robust quality assurance of practice. To do this, the provider must as a minimum:

a) Ensure that records and practices are in place to evidence the effectiveness of the service in meeting the needs of young people.

b) Ensure a robust audit system is in place and promote a shared responsibility in quality assurance processes to identify area for improvement.

This is to comply with Regulation 4(1)(a) (Welfare of Users) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) and to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (4.19) and 'I use a service and organisation that are well led and managed' (4.23).

This requirement was made on 18 November 2022.

Action taken on previous requirement
We have assessed that the current quality assurance systems and practice is adequate to have met this requirement. Some of the systems reviewed were robust and effective to review the service capacity to meet the needs of children and young people. However, we also recognised that some of the systems needed continued focus.

Met - outwith timescales

Requirement 3

By 28th February 2023, the provider should ensure that support planning documentation for children and young people takes a SMART approach (specific, measurable, achievable, relevant and time-bound). To do this the provider must, as a minimum, ensure:

a) Assessed needs are accompanied with detailed action points.
b) Professional involvement to support progression of action points is clearly recorded.
c) Delay and drift in progressing action points are addressed and recorded.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210) and to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My personal plan (sometimes referred to as my care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (HSCS 1.15) and 'I experience high quality care and support based on relevant evidence, guidance and best practice' (HSCS 4.11).

This requirement was made on 18 November 2022.

Action taken on previous requirement
A similar requirement was made for the adoption and fostering services. While we acknowledge that the court process has delayed plans for children in some cases, this was out with the control of the services.

Met - outwith timescales

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

To ensure children and young people have opportunities and benefit from participation in decisions that affect them, the provider must evidence support provided to children and young people to express their views, attend meetings and understand how their needs will be met through care planning processes.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I am fully involved in developing and reviewing my personal plan, which is always available to me' (HSCS 2.17); and 'My human rights are central to the organisations that support and care for me' (HSCS 4.1).

This area for improvement was made on 18 November 2022.

Action taken since then
Good consistent evidence of young people having a voice throughout.

This Area for Improvement has been Met.

Previous area for improvement 2

To enable the panel members to make informed and balanced decisions in the welfare of children, young people and their families, the provider should ensure suitable training and support is available to all panel members.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I use a service and organisation that are well led and managed' (HSCS 4.23).

This area for improvement was made on 18 November 2022.

Action taken since then

Current panel members did not all report having received suitable training to support their role. Of those we spoke to, not all panel members had received an annual appraisal.

This Area for Improvement is Not Met.

Previous area for improvement 3

To enable caregiver families to fully support the needs of children in their care, the provider should improve availability of training to all families. This should include, but not be limited to, trauma informed practice and attachment training.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I experience high quality care and support based on relevant evidence, guidance and best practice.' (HSCS 4.11).

This area for improvement was made on 18 November 2022.

Action taken since then

The carer training calendar had been reviewed and included a wide range of training available to foster carers and adopters. These included training topics delivered internally as well as by external providers which would support caregiving families to meet the needs of the children in their care. Child protection, adult protection and trauma informed training was mandatory for all foster carers to attend.

This Area for Improvement has been Met.

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed

How well do we support people's wellbeing?	5 - Very Good
1.1 Children, young people. adults and their caregiver families experience compassion, dignity and respect	5 - Very Good
1.2 Children, young people and adults get the most out of life	5 - Very Good
1.3 Children, young people and adults' health and wellbeing benefits from the care and support they experience	5 - Very Good
1.4 Children, young people, adults and their caregiver families get the service that is right for them	5 - Very Good

How good is our leadership?	3 - Adequate
2.2 Quality assurance and improvement are led well	3 - Adequate

How well is our care and support planned?	5 - Very Good
5.1 Assessment and care planning reflects the outcomes and wishes of children, young people and adults	5 - Very Good

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REPORT TO: DUNDEE CITY COUNCIL COMMUNITY SAFETY AND PUBLIC PROTECTION COMMITTEE

REPORT NUMBER – 137-2025

23rd April 2025

Report by Area Commander Bryan Todd, Local Senior Officer, Scottish Fire and Rescue Service

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SUBJECT: FIRE AND RESCUE QUARTERLY PERFORMANCE REPORT 1st October to 31st December 2024

Abstract
The Report contains performance information relating to the third quarter (October - December) of 2024-2025 on the performance of the Scottish Fire and Rescue Service in support of Member scrutiny of local service delivery.

1 PURPOSE OF THE REPORT

To provide information for the Committee regarding the performance of the Scottish Fire and Rescue Service against the priorities, outcomes and performance measures detailed within the Local Fire and Rescue Plan for Dundee 2020–2023, to facilitate local scrutiny.

2 RECOMMENDATIONS

It is recommended that members:

Note, scrutinise and question the content of this report.

3 FINANCIAL IMPLICATIONS

None.

4 BACKGROUND

4.1 The Local Fire and Rescue Plan for Dundee 2020-2023 was approved by the Community Safety and Public Protection Committee on 16 November 2020. In support of delivering the priorities in this plan, twelve headline indicators are utilised as performance measures and form the basis of quarterly monitoring reports.

4.2 The priorities and outcomes contained within the Local Fire and Rescue Plan reflect ‘place’ and the contribution of the Scottish Fire and Rescue Service to the City Plan for Dundee 2017-2026.

4.3 In summary the following priorities are detailed within the plan:

- Priority 1 – Improving Fire Safety in the Home
- Priority 2 – Improving Fire Safety and Resilience in the Business Community
- Priority 3 – Minimising the Impact of Unintentional Harm
- Priority 4 – Reducing Unwanted Fire Alarm Signals
- Priority 5 – Reducing Deliberate Fires
- Priority 6 – Effective Risk Management and Operational Preparedness

4.4 Appendix 1 attached to this report provides a detailed breakdown and analysis of all data collected during the reporting period. In addition, further sections are included to provide Members with an overview of a range of community safety engagement events and partnership working. Furthermore, it highlights any notable incidents and events.

5 EQUALITY IMPACT ASSESSMENT

5.1 Not applicable.

6 ENVIRONMENTAL ISSUES

6.1 There are no environmental issues arising as a consequence of this report.

7 SUMMARY

7.1 The attached report updates members regarding significant community safety engagement activities and gives context to the performance of the Scottish Fire and Rescue Service in the Dundee area against headline indicators and performance measures.

Area Commander Bryan Todd
Local Senior Officer
Perth & Kinross, Angus and Dundee
Scottish Fire and Rescue Service
Blackness Road
Dundee
DD1 5PA

QUARTERLY MONITORING REPORT

Covering the activities and performance in support of the Local Fire and Rescue Plan for Dundee 2020-2023

Quarter Three: 2024-2025

Dundee City Council www.dundeecity.gov.uk CHANGING FOR THE FUTURE

ABOUT THE STATISTICS IN THIS REPORT

The activity totals and other statistics quoted in this report are provisional in nature and subject to change as a result of ongoing quality assurance and review.

Because all statistics quoted are provisional there may be differences in the period totals quoted in our reports after original publication which result from revisions or additions to the data on our systems.

From 2015-16 onwards responsibility for the publication of end-year statistical data transferred from the Scottish Government to the SFRS. This change of responsibility does not change the status of the figures quoted in this and other SFRS reports reported to the Committee.

TABLE OF CONTENTS **PAGE**

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INTRODUCTION

This is the quarter three (Q3) monitoring report for 2024/25, covering the SFRS's performance and activities in support of the six priorities in the Local Fire and Rescue Plan for Dundee 2020-2023, namely:

- Priority 1 - Improving fire safety in the home
- Priority 2 - Improving fire safety and resilience in the business community
- Priority 3 - Minimising the impact of unintentional harm
- Priority 4 - Reducing unwanted fire alarm signals
- Priority 5 - Reducing deliberate fires
- Priority 6 - Effective risk management and operational preparedness

As well as supporting the six priorities in the Local Fire and Rescue Plan for Dundee, this monitoring report shows how SFRS activities and performance contribute to the wider priorities of the Dundee Partnership as set out in the City Plan for Dundee 2017-2026.

The figures in this report are provisional, to provide the Committee with the SFRS's direction of travel in the Dundee area, in terms of performance against headline indicators and targets. Most figures will not change; however, members should note that there may be some small variations for some indicators when the final confirmed figures are published by the SFRS.

The Community Safety and Public Protection Committee agreed the new Local Fire and Rescue Plan for Dundee 2020-2023 on 16 November 2020. In support of delivering the priorities in this plan, 12 headline indicators and targets have been set and form the basis of this quarterly monitoring report.

PERFORMANCE SUMMARY

The table below provides a summary of 2024/25 Q3 activity and year to date (YTD) performance against headline indicators and annual targets. It aims to provide at a glance, our direction of travel during the current reporting year.

HI 1 **Accidental Dwelling Fires (ADF)**  **Q3 – 33 Incidents** **YTD – 106 incidents** **Annual Target – below 175**	**HI 2** **ADF Fatal Casualties**  **Q3 – 0** **YTD – 0** **Annual Target – 0**	**HI 3** **ADF Non-Fatal Casualties**  **Q3 – 1** **YTD – 24** **Annual Target – below 30**
HI 4 **Non-Domestic Building Fires**  **Q3 – 6 Incidents** **YTD – 18 Incidents** **Annual Target – below 37**	**HI 5** **Fatal Casualties in Non-Domestic Building Fires**  **Q3 – 0** **YTD – 0** **Annual Target – 0**	**HI 6** **Non-Fatal Casualties in Non-Domestic Building Fires**  **Q3 – 0** **YTD – 0** **Annual Target – below 2**
HI 7 **Road Traffic Collision (RTC) Incidents**  **Q3 – 9 Incidents** **YTD – 31 Incidents** **Annual Target – below 41**	**HI 8** **Fatal RTC Casualties**  **Q3 – 0** **YTD – 0** **Annual Target – 0**	**HI 9** **Non-Fatal RTC Casualties**  **Q3 - 5** **YTD - 13** **Annual Target – below 19**
HI 10 **Unwanted Fire Alarm Signals**  **Q3 – 191 Incidents** **YTD – 544 Incidents** **Annual Target – below 1176**	**HI 11** **Deliberate Primary Fires**  **Q3 – 44 incidents** **YTD - 94 Incidents** **Annual Target – below 63**	**HI 12** **Deliberate Secondary Fires**  **Q3 – 203 Incidents** **YTD - 519 Incidents** **Annual Target – below 512**

Year-to-Date Legend

	**Below headline target**
	**Less than 10% above headline target**
	**More than 10% above headline target**

PERFORMANCE HIGHLIGHTS

Of the 12 headline indicators and targets, the following summary should be noted for Q3 2024/25:

Priority 1 - Improving fire safety in the home
Accidental Dwelling Fires in Dundee continue to follow a downward trend over the three years, 33 incidents with 23 of these where fire fighters did not require to take any action and from the remaining 10 the action was limited with only two evacuations required. Reporting zero fatal casualties and only one non-fatal casualty in Q3 where a precautionary check was advised by crews. Year to date number for non-fatal 24 includes 20 suspected of smoke inhalation with six going for hospital checks and eight being administered oxygen by fire fighters on scene.

Priority 2 - Improving fire safety and resilience in the business community
Non-Domestic fires in Dundee are also following a downward trend for the year-to-date totals. Only three of the incidents required firefighting and those were limited interventions with damage limited to item first ignited or the room of origin. Automatic Fire alarm systems were present in all premises.

Priority 3 - Minimising the impact of unintentional harm
There were nine RTCs over the quarter bringing the year to date back into line with a reduction from quarter two. No trends regarding locus, time of day or vehicle types identified. Reporting zero fatal casualties and five non-fatal, only one extrication required with removal to hospital, the remaining four had precautionary checks by Fire Fighters and SAS.

Priority 4 - Reducing unwanted fire alarm signals
SFRS attended 191 UFAS incidents in Q3. This follows the expected trend following introduction of the UFAS reduction strategy. A list of the top five property types and causation is included on page 15 of this report. Despite these welcome reductions local SFRS managers continue to work with our colleagues in legislative fire safety to ensure repeat offenders are supported and educated to drive these incidents down further in premises where we have repeat activations.

Priority 5 - Reducing deliberate fires
In Q3 there were 44 deliberate primary fires in the city, this is an increase on the last quarter but the year to date is lower than the three-year average. Deliberate vehicle fires continue to increase with over 50% of these incidents (24) being vehicle related.
We would expect to see an increase in this quarter in deliberate secondary fires due to bonfire night and Halloween antisocial activity across the city. Most of these incidents occurred across the north of the city and were mainly bin fires.

Priority 6 - Effective risk management and operational preparedness

Firefighters continue to deliver preventative educational information in the domestic, educational and business settings at every opportunity.
They also focus on maintaining and enhancing their skills in preparedness for operational incidents through a range of activities including training and information gathering in their local area.

Full details of Q3 activity are on page 18 of this report and within Appendix 2.

PRIORITY 1 - IMPROVING FIRE SAFETY IN THE HOME

HI 1 – Accidental Dwelling Fires (ADF)

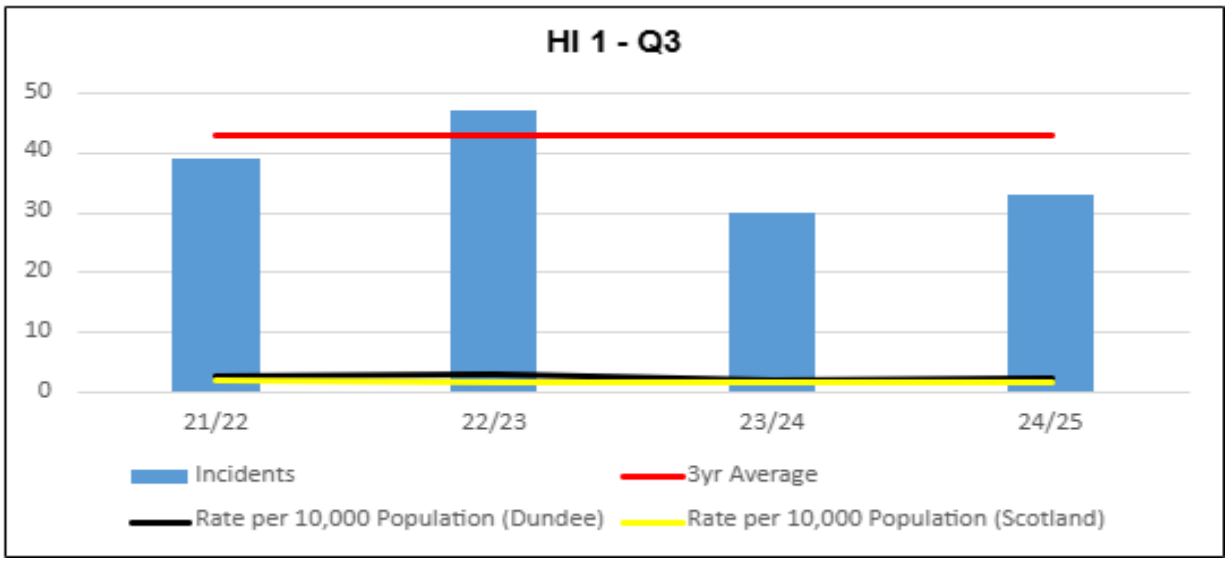


Table 1: Year to Date Performance

	21/22	22/23	23/24	24/25	YTD	Annual Target
HI 1: ADF's	115	126	111	**106**	**Green**	**Below 175**

HI 2 - ADF Fatal Casualties & HI 3 - ADF Non-Fatal Casualties

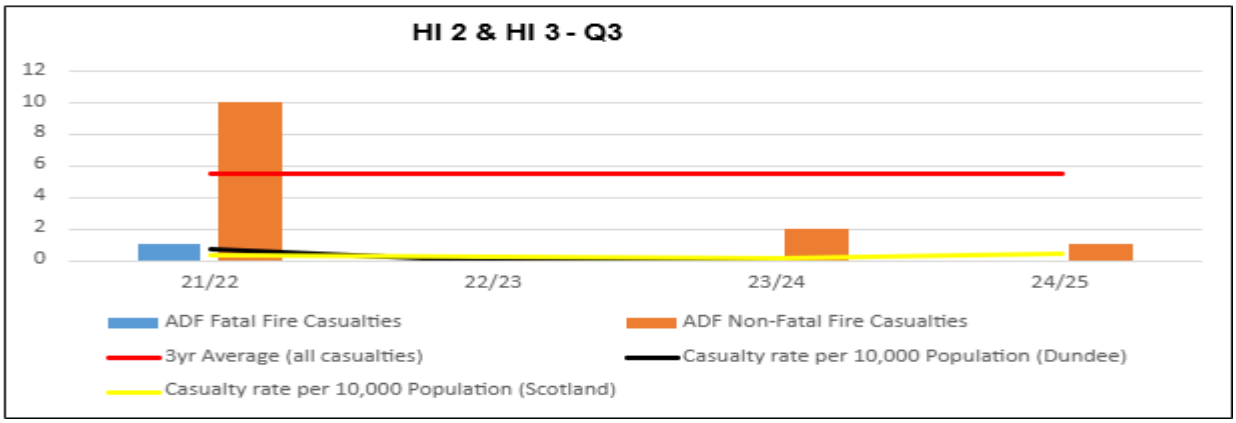


Table 2: Year to Date Performance

	21/22	22/23	23/24	24/25	YTD	Annual Target
HI 2: ADF Fatal Casualties	1	2	0	**0**	**Green**	**0**
HI 3: ADF Non-Fatal Casualties	24	15	8	**24**	**Amber**	**Below 30**

Indicator Description

The largest single type of primary fire in Dundee is accidental fires in the home and their prevention is a key focus of the Service's community safety activity.

HI 1 – Accidental Dwelling Fires (ADF)

As a headline target, the aim is to reduce the rate of ADF's by keeping these incidents below 175, during 2023/24

HI 2 – ADF Fatal Casualties

This indicator concentrates on members of the community for whom fire has been clearly identified as the cause of death, even if they die some-time after the actual fire. Those who die at, or after, the fire but where fire is not identified as the cause of death, are not included within these figures.

As a headline target, the optimum aim is to always strive to have zero ADF Fatal Casualties in Dundee City.

HI 3 – ADF Non-Fatal Casualties

This headline target counts all types of non-fatal fire injury in the home, including precautionary checks.

As a headline target, the aim is to reduce the risk of injury from fire in the home by keeping fire injuries below 30, during 2023/24

What we aim to Achieve

As well as helping to deliver Priority One: *Improving Fire Safety in the Home*, meeting the headline targets will also support the long-term ambition of the City Plan for Dundee and supports achievement of the following local outcomes:

- Our people will be better educated and skilled within a city renowned for learning and culture;
- Our children will be safe, healthy, achieving, nurtured, active, respected, responsible and included;
- People in Dundee will be able to live independently and access support when they need it;
- Our communities will be safe and feel safe.

Performance Management

SFRS Dundee CAT and crews continue to be fully engaging with all aspects of the community delivering High Risk HFSV's. Numerous Joint Home Fire Safety Visits ongoing with Dundee CAT members and Community Mental Health Teams, Dundee City Council Home Care Assessors, Community Housing Teams, Some Joint High-Risk Visits completed due to concerns for occupier's wellbeing. Several High-profile partnership visits in this last 1/4 close working with DIDARS, Police Scotland, Dundee Housing and Community Mental Health Teams.

Operational Crews delivered 267 visits and CAT 50 totalling 317 visits across Dundee in Q3.
59 Post Domestic Incident Responses were carried out within Dundee City giving guidance and reassurance following major and minor incident relating to house fires
The community Action are in the process of re linking with community groups and attending at LCPP's in each ward to understand better the issues and concerns in each area.

PRIORITY 2 – IMPROVING FIRE SAFETY AND RESILIENCE IN THE BUSINESS COMMUNITY

HI 4 – Non-Domestic Building Fires

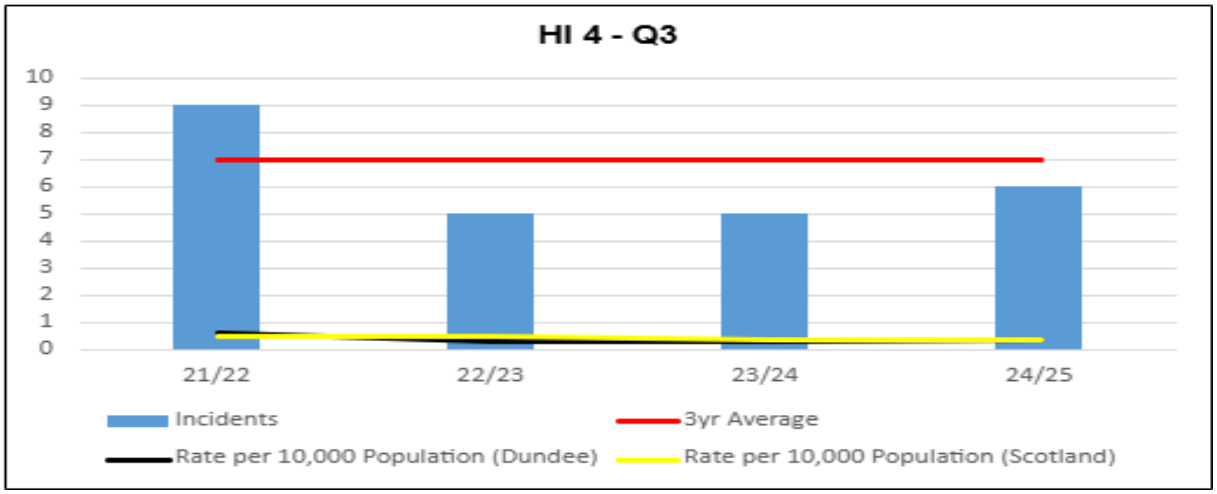


Table 3: Year to Date Performance

	21/22	22/23	23/24	24/25	YTD	Annual Target
HI 4: Non-Domestic Building Fires	30	29	22	18	**Green**	**Below 37**

HI 5 – Fatal Fire Casualties in Non-Domestic Buildings & HI 6 – Non-Fatal Fire Casualties in Non-Domestic Buildings

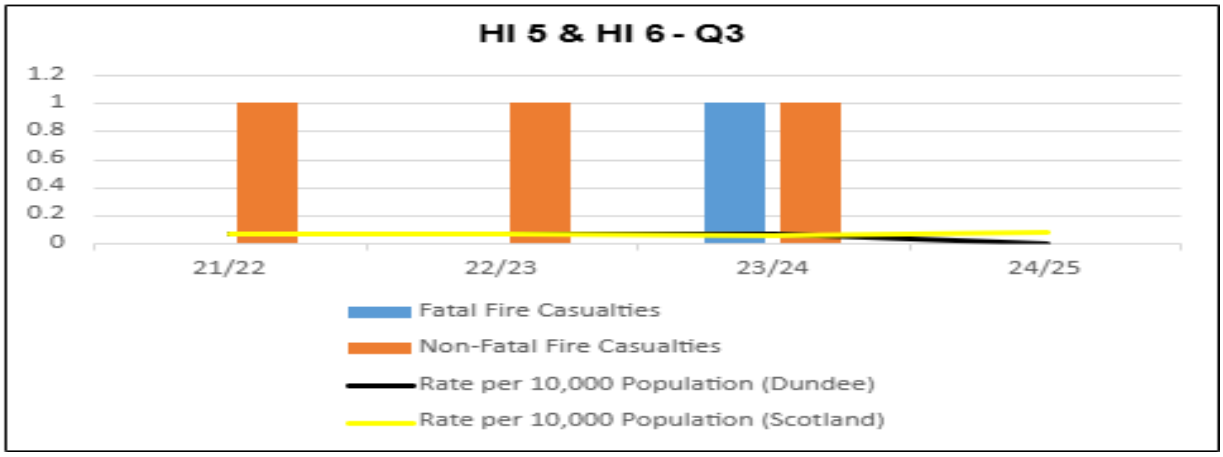


Table 4: Year to Date Performance

	21/22	22/23	23/24	24/25	YTD	Annual Target
HI 5: Fatal Fire Casualties	0	0	1	**0**	**Green**	**0**
HI 6: Non-Fatal Fire Casualties	1	1	1	**0**	**Green**	**Below 2**

Indicator Description

These headline indicators and targets cover the types of non-domestic buildings applicable to Part 3 of the Fire (Scotland) Act 2005 ('The Act') (e.g. care homes, hotels and hospitals) and is designed to reflect the effectiveness of fire safety management in respect of these types of buildings.

HI 4 - Non-Domestic Building Fires Applicable to the Act

As a headline target, the aim is to reduce the rate of accidental fires in non-domestic buildings (where 'The Act' applies), by keeping these fires below 37 in Dundee during 2023/24

HI 5 – Fatal Fire Casualties in Non-Domestic Building Fires Applicable to the Act

This indicator counts those people for whom fire has been clearly identified as the cause of death, even if they die some time after the actual fire. Those who die at, or after, the fire but where fire is **not** identified as the cause of death are not included in these figures. As a headline target, the aim is to have zero Fatal Fire Casualties in non-domestic buildings applicable to the Act, in Dundee during 2023/24

HI 6 – Non-fatal Fire Casualties in Non-Domestic Building Fires Applicable to the Act

This headline target counts all types of non-fatal fire injury in non-domestic buildings, including precautionary checks. As a headline target, the aim is to reduce risk of injury from fire in non-domestic buildings, by keeping fire injuries at one in Dundee during 2023/24

What we aim to Achieve

As well as helping to deliver Priority Two: *Improving Fire Safety and Resilience in the Business Community*, meeting the headline targets will also support the long-term ambition of the City Plan for Dundee and supports achievement of the following local outcomes:

- Dundee will be an internationally recognised city at the heart of a vibrant region with more and better employment opportunities for people;
- Our communities will be safe and feel safe;
- Our people will live in strong, popular and attractive communities.

Performance Management

Our dedicated Fire Safety Enforcement Officers continue to audit relevant premises that fall within the scope of the Fire (Scotland) Act 2005 to ensure compliance with their statutory responsibilities.
The target set for the year is 366 fire safety audits. During Q3 a total of 92 premises that fall within the scope of the Act were audited. The breakdown of these are as follows: 62 HMOs; 19 Care Homes; 2 licensed premises; 2 University Buildings; 2 hotels; 1 Monastery; 1 hospital; 1 workshop; 1 convent; 1 shop. Of these, Five were Post Fire Audits to provide support and guidance following an event (2 university buildings, 1 shop, 1 care home, 1 licensed premises DCA).
No patterns or trends were identified across these premises and support and guidance were given to improve fire safety management in the workplace in relation to the cause of the incident.
Ongoing work with Dundee City Council to consult with and support the licensing of Short Term Lets throughout the city continues.
A total of nine Short term Let applications were submitted to SFRS from Dundee City Council in Q3 resulting in one specific visit & three consultations from SFRS.
Six Fire Engineering consultations were completed, along with six consultations including short term lets, childminder applications, and complaints and concerns.18 specific visits including 10 high rise inspections, HMO visits, and complaints and concerns.

PRIORITY 3 – MINIMISING THE IMPACT OF UNINTENTIONAL HARM

HI 7 – Road Traffic Collision (RTC) Incidents

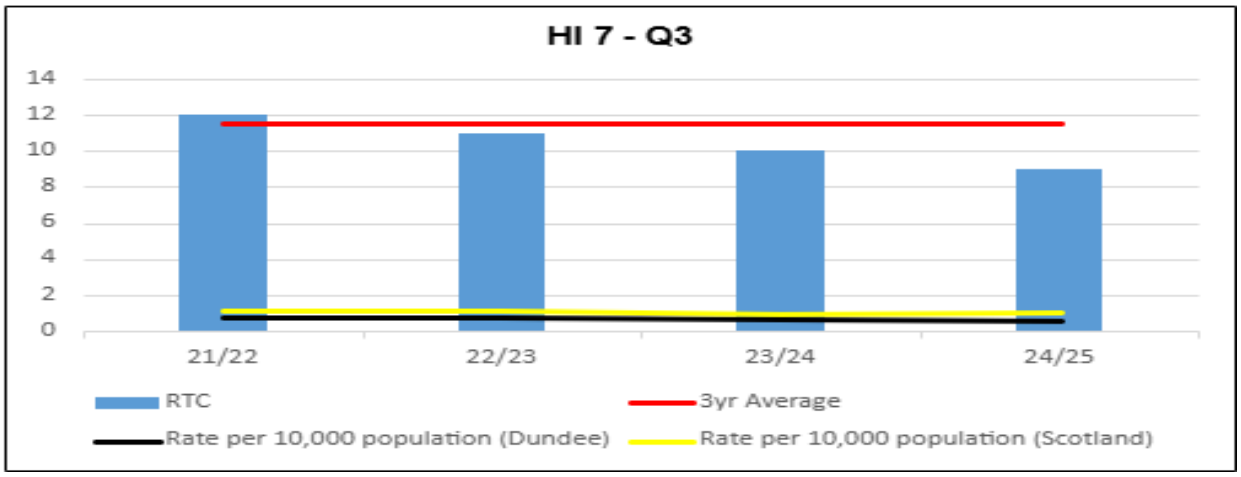


Table 5: Year to Date Performance

	21/22	22/23	23/24	24/25	YTD	Annual Target
HI 7: RTC Incidents	35	40	30	**31**	**Green**	**Below 41**

HI 8 – Fatal RTC Casualties & HI 9 – Non-Fatal RTC Casualties

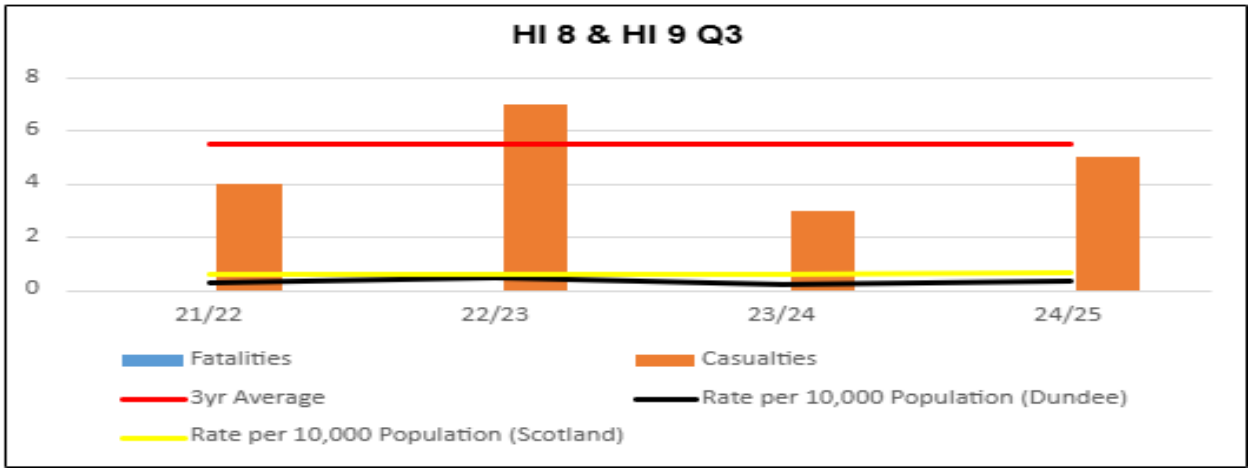


Table 6: Year to Date Performance

	21/22	22/23	23/24	24/25	YTD	Annual Target
HI 8: Fatal RTC Casualties	0	0	1	0	**Green**	**0**
HI 9: Non-Fatal RTC Casualties	20	18	8	**13**	**Green**	**Below 19**

Indicator Description

The SFRS has become increasingly involved in more non-fire related prevention work, in support of its role in promoting the wider safety and well-being of its communities, including minimising the impact of unintentional harm. The headline indicators and targets reflect the fact that most of non-fire related casualties attended by the SFRS in Dundee are at RTC Incidents.

HI 7 - RTC Incidents
As a headline target, the aim is to reduce the rate of RTC incidents, by keeping them below 41 during 2023/24.
HI 8 – Fatal RTC Casualties
As a headline target, the aim is to reduce the risk of death from RTC's in Dundee, by keeping the number of fatal RTC casualties at 0 during 2023/24.
HI 9 - Non-fatal RTC Casualties
As a headline target, the aim is to reduce the risk of injury from RTC's in Dundee, by keeping non-fatal RTC casualties below 19 during 2023/24.

What we aim to Achieve

As well as helping to deliver Priority Three: *Minimising the Impact of Unintentional Harm*, meeting the headline targets will also support the long-term ambition of the City Plan for Dundee and supports achievement of the following local outcomes:

- Our people will be better educated and skilled within a city renowned for learning and culture
- Our children will be safe, healthy, achieving, nurtured, active, respected, responsible and included
- People in Dundee will be able to live independently and access support when they need it
- Our communities will be safe and feel safe

Performance Management

New Driver Scheme and Fatal 5s

SFRS Crews and CAT supported the delivery of educational initiatives including successful engagement with High school of Dundee this Quarter with the new driver scheme and fatal 5s delivered to all Senior Schools at Mayfield Campus, this partnership work included input from SAS and Police Scotland

Pro Active Work (Panderbull – MoonBeam)

Over this Quarter the focus has be as per last year to get the relevant and proper messages across in the lead up to Halloween and the Kirkton disturbances and bonfire night

During this period Both operational crews and Community action teams have been working with internal and external partners (Police Scotland and Anti-Social Behaviour Teams at DCC) to drive the message that fire related ASB and attacks on emergency service personal will not the tolerated.

This Quarter saw blanket deliveries at St Pauls, Baldragon and St John a huge and positive buy in from all school and Head Teachers in collaboratively working to reduce incidents over this period.

More information within Appendix1.

PRIORITY 4 – REDUCING UNWANTED FIRE ALARM SYSTEMS

HI10 – Unwanted Fire Alarm Signals (UFAS)

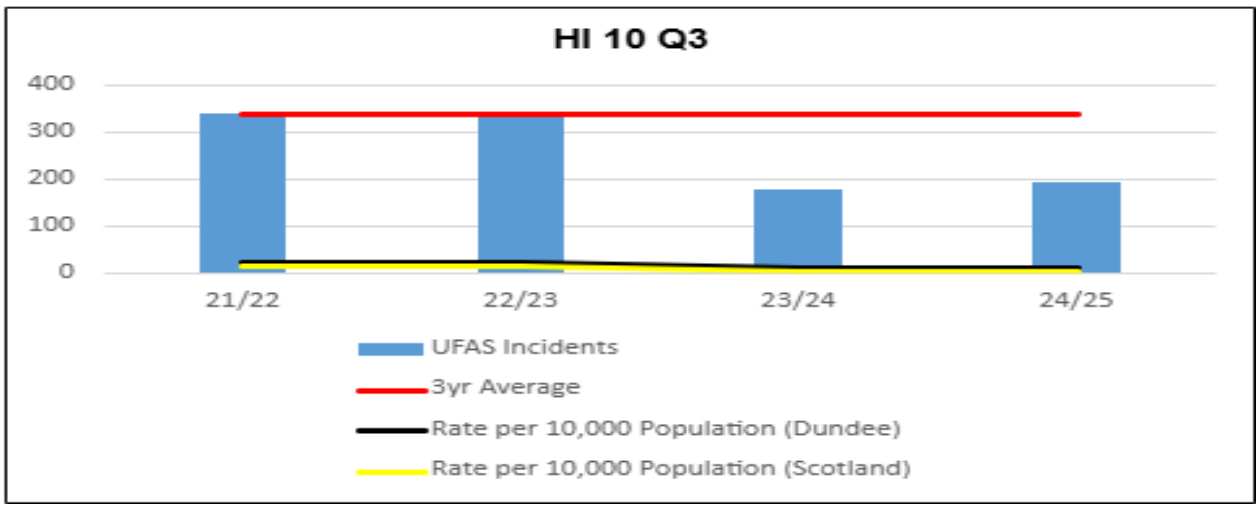


Table 7: Year to Date Performance

	21/22	22/23	23/24	24/25	YTD	Annual Target
HI 10: UFAS Incidents	855	984	707	**544**	**Green**	**Below 1176**

Indicator Description

Automatic Fire Alarms (AFA) are fundamental to providing early warning from fire, giving people the chance to evacuate safely. However, to be effective, they must be properly installed and maintained, and a good fire safety management regime must be in place by the duty holder, so they do not activate when there is no fire.

Every Unwanted Fire Alarm Signal from an AFA has an impact in terms of unnecessary blue light journeys, redirecting SFRS resources away from other activities such as community safety work and causing considerable disruption to businesses.

HI 10 – Unwanted Fire Alarm Signals (UFAS)

As a headline target, the aim is to improve fire safety management and awareness, by reducing the number of attendances to unwanted fire alarm signals (UFAS) from automatic systems in non-domestic buildings to less than 1176 during 2023/24.

What we aim to Achieve

As well as helping to deliver Priority Four: *Reducing Unwanted Fire Alarm Signals*, meeting the headline targets will also support the long-term ambition of the City Plan for Dundee and supports achievement of the following local outcomes:

- Dundee will be an internationally recognised city at the heart of a vibrant region with more and better employment opportunities for people;
- Our people will be better educated and skilled within a city renowned for learning and culture;
- Our children will be safe, healthy, achieving, nurtured, active, respected, responsible and included;
- Our communities will be safe and feel safe.

Performance Management

In Q3, SFRS were called out to 191 UFAS incidents in the city of Dundee compared to 190 in the same quarter last year. With the UFAS reduction strategy now being in place for a year we expect to see these numbers stabilise. This means less unnecessary blue light journeys, increased appliance availability for real incidents and less disruption to training and community safety events. However, your local SFRS managers are focused on further reduction to prevent these journeys and reduce risk where possible through interaction with duty holders to educate and support required change.

The table below lists the top five property types that had persistent call-outs due to UFAS during Q3.

Property Types	No. of UFAS
Residential - Student Halls of Residence	66
Hospitals/Medical Care	49
Residential – Care homes	19
Residential – Sheltered housing	9
Residential – other	7

The Westend of Dundee placed the highest burden of resources with 133 turnouts for UFAS events. This results in multiple appliance blue light journeys for each individual turnout and presents unnessisary risk to crews and the public. The ledgislative team in Dundee are working with the duty holders in these premises to provide solutions as causation is based mostly around human behavior and system faults. Both can be reduced with the correct education, action plans and fire safety management arrangements.

PRIORITY 5 – REDUCING DELIBERATE FIRES

HI 11 – Deliberate Primary Fires

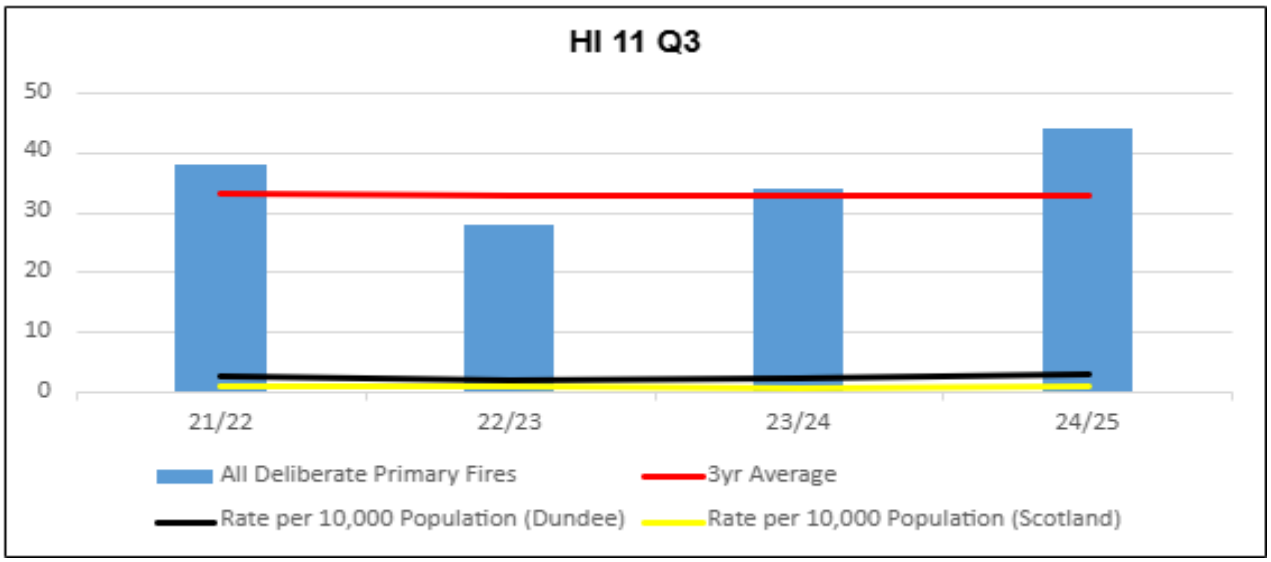


Table 8: Year to Date Performance

	21/22	22/23	23/24	24/25	YTD	Annual Target
HI 11: Deliberate Primary Fires	88	103	121	**94**	**Red**	**Below 63**

HI 12 – Deliberate Secondary Fires

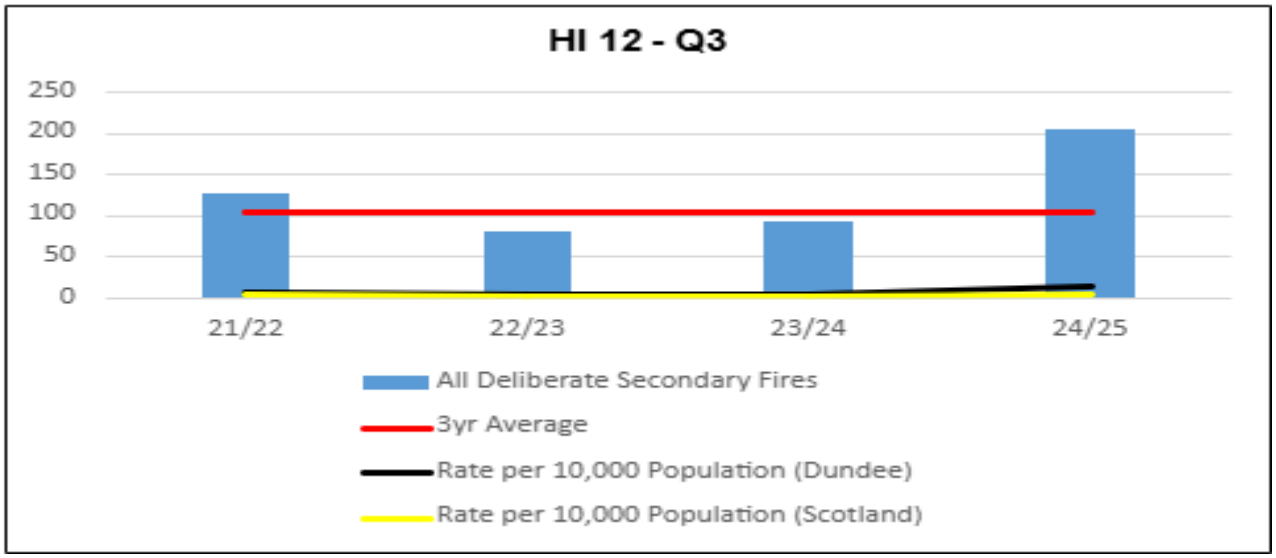


Table 9: Year to Date Performance

	21/22	22/23	23/24	24/25	YTD	Annual Target
HI 12: Deliberate Secondary Fires	520	534	433	519	**Red**	**Below 512**

Indicator Description

These headline and indicator targets account for all types of fire that are believed to have been started intentionally and are categorised as Deliberate Primary Fires and Deliberate Secondary Fires.

HI 11 – Deliberate Primary Fires

These deliberate fires cover the following types:

- Fires in the home
- Fires in non-domestic buildings
- Fires in motor vehicles

As a headline target, the aim is to reduce the rate of deliberate primary fires in Dundee by keeping these fires below 63 during 2023/24.

HI 12 – Deliberate Secondary Fires

These deliberate fires cover the majority of outdoor fires including grassland and refuse fires and include fires in derelict buildings, but not chimney fires. As a headline target, the aim is to reduce the rate of deliberate secondary fires in Dundee by keeping these fires below 512 during 2023/24.

What we aim to Achieve

As well as helping to deliver Priority Five: *Reducing Deliberate Fires*, meeting the headline targets will also support the long-term ambition of the City Plan for Dundee and supports achievement of the following local outcomes:

- Dundee will be an internationally recognised city at the heart of a vibrant region with more and better employment opportunities for people;
- Our children will be safe, healthy, achieving, nurtured, active, respected, responsible and included;
- Our communities will be safe and feel safe;
- Our people will live in strong, popular and attractive communities.

Performance Management

Proactive Schools/community engagement for Operations Panderbull & Moonbeam

Over this Quarter the focus has be as per last year to get the relevant and proper messages across in the lead up to Halloween and the Kirkton disturbances and bonfire night. This approach resulted in a reduction in not just antisocial fire raising but also public order offences involving attacks on emergency workers in Dundee. During this period Both operational crews and Community action teams have been working with internal and external partners (Police Scotland and Anti-Social Behaviour Teams at DCC to drive the message that fire related ASB and attacks on emergency service personal will not the tolerated.

SFRS continue to work around and have a presence in areas where repeat incidents occurred where we target schools and groups to engage in diversionary engagements when children can learn through practical learning or SFRS staff giving talks on the effects of ASB and wilful fire raising in communities. This Quarter saw different types of educational delivery at St Paul`s, Baldragon and St John`s. There was a huge and positive buy in from all school and Head Teachers in collaboratively working to reduce incidents over this period. SFRS staff were happy to adapt to the individual needs for each school to ensure messages were delivered to the key audiences.

PRIORITY 6 – EFFECTIVE RISK MANAGEMENT AND OPERATIONAL PREPAREDNESS

Description

Risk Management and operational preparedness is a key area of work for the SFRS. In Dundee, this means:

- Knowing what the risks are in Dundee and then making plans, so we are resilient to respond to any event.
- Being prepared to respond to national threats or major emergencies.
- Developing flexibility to deploy crews, to take on a broadening role within the community.
- Firefighters being equipped to deal with emergencies safely and effectively and our stations being in a constant state of readiness.

What we aim to Achieve

As well as helping to deliver Priority Six: *Effective Risk Management and Operational Preparedness*, our activities will also support the long-term ambition of the City Plan for Dundee and supports achievement of the following local outcomes:

- Dundee will be an internationally recognised city at the heart of a vibrant region with more and better employment opportunities for people
- Our communities will be safe and feel safe
- Our people will live in strong, popular and attractive communities

Activity

Training

During Q3 2024/25, we delivered our quarterly training commitment to operational firefighters, whereby we trained and confirmed their preparedness to deal with:

- Breathing Apparatus
- RTC – E-Draulic Tools handling
- Water Awareness
- Knots and Lines
- Safe working at height
- Pumps and Ladders

Advanced modules

- Civil Disturbance GRA
- Home Fire Safety – Procedural changes
- Farm Fires GRA

Gathering and updating operational intelligence

Crews continue to visit properties to gather, amend and update information that can then be accessed by Incident Commanders at incidents and allow safe systems of work to be put in place that take consideration of information specific to the property and contents involved. Specific information on derelict buildings in the area has been shared with crews and work is ongoing with partners to mitigate the risks.

Community Safety - Educational Events – Operational pre planning

Crews were heavily involved in the preplanning, community, and educational events in the lead up to Halloween and Bonfire night - **Ops Panderbull and Moonbeam**

APPENDIX 1: COMMUNITY SAFETY ENGAGEMENT & PARTNERSHIP WORKING

Proactive Schools engagement pre planning for Ops Panderbull & Moonbeam

Over this Quarter the focus has been the same as last year, to get the relevant and proper messages across in the lead up to Halloween for the potential Kirkton disturbances and bonfire night.

During this period both operational crews and Community action teams have been working with internal and external partners (Police Scotland and Anti-Social Behaviour Teams at DCC) to drive the message that fire related ASB and attacks on emergency service personal will not the tolerated.

Operational crews delivered to Primary age grade young people with a targeted audience of p6-7s.

This Quarter saw different types of educational delivery at St Paul`s, Baldragon and St John`s. There was a huge and positive buy in from all school and Head Teachers in collaboratively working to reduce incidents over this period. SFRS staff were happy to adapt to the individual needs for each school to ensure messages were delivered to the key audiences.

Schools took different approaches. St Paul's was a blanket assembly session where we targeted S1,2 &3, whereas Baldragon requested a targeted approach where we delivered to PCS classes 25-30 at a time, both delivery types having positive outcomes with a reduction in fire related incident over this period.

SFRS continue to work around and have a presence in areas where repeat incidents occurred were we target school and group to engage in diversionary engagements when children can learn through practical learning or SFRS staff giving talks on the effects of ASB and wilful fire raising in communities.

APPENDIX 2: NOTABLE INCIDENTS & TRAINING EVENTS

Partnership Working with Dundee City Council Building Standards Team (DCCBST)

A request was received from the Building Standards Team at Dundee City Council for a familiarisation session on the Arial Ladder Platform (ALP) based at Blackness Road Community Fire Station.

The session delivered by Red Watch from Blackness Road gave the DCCBST a useful insight into the capabilities and use of the ALP as many of the team had never seen the appliance before.

The team were given the opportunity to rig in a harness and “fly” in the cage, this practical experience prepares the team members for any requirement to do the same under operational circumstances and have a full understanding of what PPE and safety requirements are required.

Search and Rescue Exercise at DC Thompson & CO

Green Watch Kingsway arranged and co-ordinated a large-scale exercise at the DC Thomson site on Kingsway East.

This Multi Pump exercise was held at a large, downscaled site formerly specialising in printing newspapers and magazines, now largely unused and hosts a vacant office block.

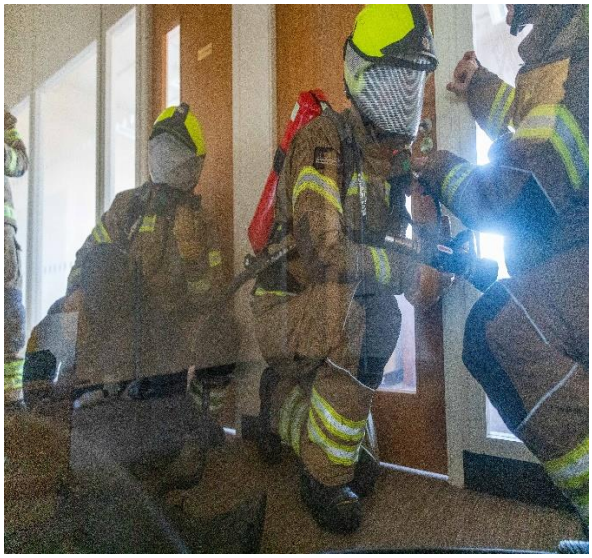
This facility allows crews to practice search and rescue in a large complex area that is safe but realistic to that type of risk and Incident Commanders to formulate plans based on Incident information, Priorities, implement tactical plan to resolve the incident and then conduct debriefs of crews.

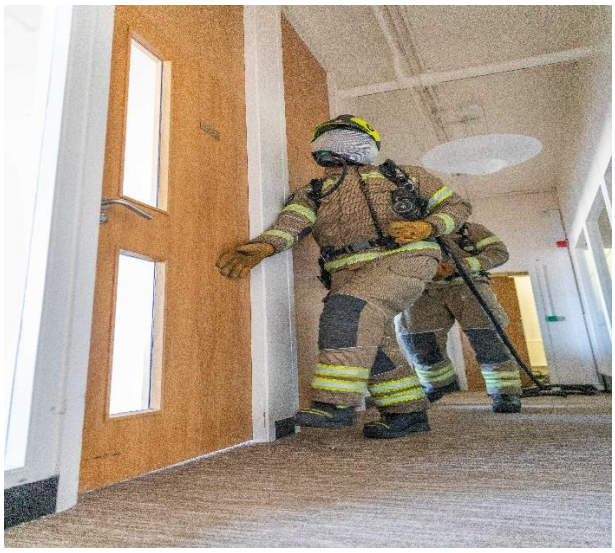
It also provided Fire Fighters in development phase to gain evidence against their SVQ portfolios.

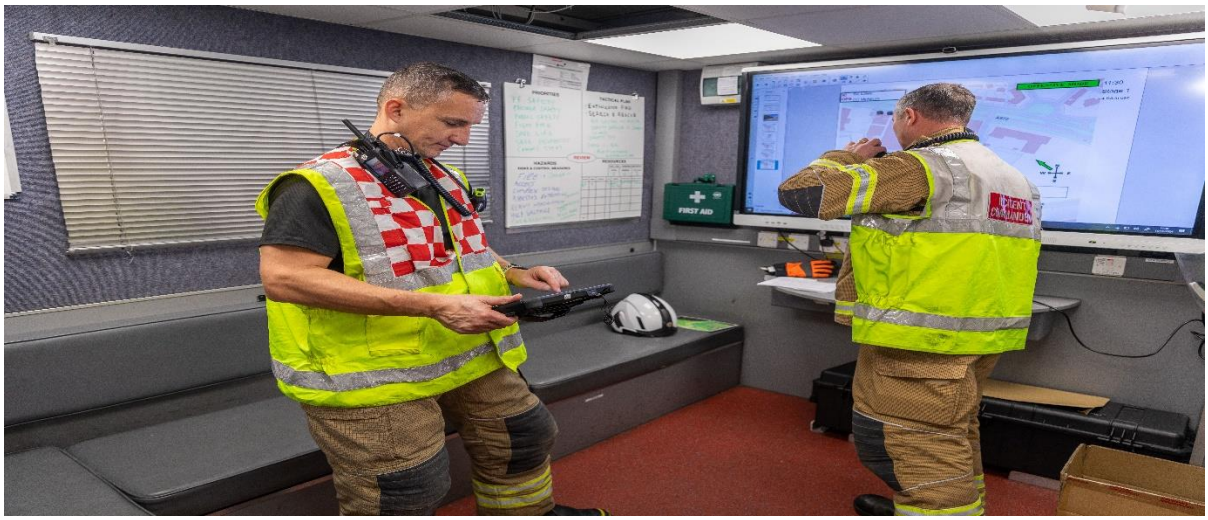
Scenario as follow;

Turnout to - Fire within the building now extinguished. Multiple persons reported and unaccounted for within Office Block. Search and Rescue of area with Level 2 attendance. P04P1 P02P1 P02P2 P03P1 P03P2 P05P1

Search and Rescue teams wore Breathing Apparatus with facemask shields to allow zero visibility, simulation of moving in smoke and darkness.







ITEM No …5……..

REPORT TO: **SCRUTINY COMMITTEE - 23 APRIL 2025**

REPORT ON: **INTERNAL AUDIT REPORTS**

REPORT BY: **CHIEF INTERNAL AUDITOR**

REPORT NO: **126-2025**

1.0 PURPOSE OF REPORT

To submit to Members of the Scrutiny Committee a summary of the Internal Audit Reports finalised since the last Scrutiny Committee.

2.0 RECOMMENDATIONS

Members of the Committee are asked to note the information contained within this report.

3.0 FINANCIAL IMPLICATIONS

None

4.0 MAIN TEXT

4.1. The day-to-day activity of the Internal Audit Service is primarily driven by the reviews included within the Internal Audit Plan. On completion of a specific review, a report which details the audit findings and recommendations is prepared and issued to management for a formal response and submission of management's proposed action plan to take the recommendations forward. Any follow-up work subsequently undertaken will examine the implementation of the action plan submitted by management.

4.2. Executive Summaries for the reviews which have been finalised in terms of paragraph 4.1 above since the last Scrutiny meeting are provided at Appendix A. The full reports are available to Elected Members on request. Reporting in Appendix A covers:

Audit	**Assurance level**
Pentana	Substantial Assurance
Permanence	Substantial Assurance
Health and Safety Risk Assessments and Incident Management in Schools	Substantial Assurance
Tay Cities Region Deal	Substantial Assurance
Financial Forecasting	Substantial Assurance
Purchase to Pay	Substantial Assurance

4.3. Internal audit recommendations are categorised as either relating to the design of the control system (Design) or compliance with the operation of the controls (Operational).

5.0 POLICY IMPLICATIONS

This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services, or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6.0 CONSULTATIONS

The Council Leadership Team have been consulted in the preparation of this report.

7.0 BACKGROUND PAPERS

None.

CATHIE WYLLIE, CHIEF INTERNAL AUDITOR **31 MARCH 2025**

(i) INTERNAL AUDIT REPORT 2023/03

Client	**Chief Executives Service and Corporate Services**
Subject	**Pentana**

Executive Summary

Conclusion

Substantial Assurance
Processes and procedures for the use of the Pentana system are well established and generally work effectively. However, determining the most significant Council plans and formalising how these should be recorded and reported through Pentana would provide greater assurance that key actions and objectives are being managed effectively, while still providing Services, Divisions, and teams with flexibility in their approach to use of its tools.

Background

Pentana Risk is an Enterprise Performance and Risk Management solution by Ideagen. It has been adopted as the sole Corporate Performance Management System, and more recently Enterprise Risk Management system, used within Dundee City Council.

The system enables the recording, update, assignment, tracking, and reporting of organisational Risks and Performance Indicators (PIs). An action tracking mechanism provides oversight of the completion of Actions agreed in the course of the review of Risks and PIs, and actions agreed through the operation of scrutiny process such as internal audit reviews.

Pentana currently tracks the Council's Corporate risk register and 5 Service level risk registers, in addition to Service Area operational risk registers and risk registers for partner organisations. Each risk is recorded in a standard format, with a named risk owner responsible for its maintenance and review. Where action is required arising from risk review, Pentana supports the recording of that action and the tracking of its completion.

Over 800 Performance Indicators have been captured on Pentana, from the Council's City Plan, Council Plan, and other operational plans. These underpin internal dashboards and public reporting of performance.

Scope

Review of the Council's Performance and Risk Management system in terms of management reporting and efficiencies.

This review considered both Corporate Reporting, meaning the arrangements implemented through Pentana to support reporting to Council Committees, and the use of Pentana within Services.

Objectives		Action Priority			
		C	H	M	L
Objective 1: Confirm that Risks recorded on Pentana are complete, up to date and recorded in line with the Risk Management Framework	**Comprehensive Assurance**	-	-	-	-
Objective 2: Confirm that Performance indicators are represented on Pentana in line with the Performance Management Framework and appropriately maintained	**Substantial Assurance**	-	-	1	-
Objective 3: Determine if groups and individuals responsible for the management of risks, performance measures and actions make effective and efficient use of reporting tools and that this is consistent across services	**Comprehensive Assurance**	-	-	-	-
Objective 4: Confirm that where Risks, Performance Indicators and Actions are not updated, the matter is escalated, and appropriate action taken	**Substantial Assurance**	-	-	1	-
TOTAL		-	-	2	-

Nature of Recommendations

All of the recommendations identified relate to the design of the control framework, as opposed to issues with the operation of existing controls.

Key Findings

We identified a number of areas of good practice:

- Policy and Procedure documentation sets out how Pentana should be used to support the Council's approach to Risk Management.
- The Performance Management Framework sets out a general approach to the use of Pentana in relation to actions and performance indicators identified in key Council Plans.
- Pentana system administrators are provided with access to self-service training material.
- Scrutiny and oversight processes vary throughout the Council, however they generally work well to ensure that Performance Indicators and Actions are kept up to date.
- In practice, the approaches adopted by Management to escalate instances in which Pentana has not been updated work well.

The Performance Management Framework is in the course of being updated, and we understand that some matters identified in this report are already being considered for inclusion in the revised version.

We have identified the following areas for improvement, which are primarily low risk actions relating to the design of controls, and represent opportunities to strengthen existing arrangements:

- Although the Performance Management Framework establishes that performance indicators should be recorded within Pentana, it does not set out a detailed approach to managing and keeping those performance indicators up to date. Identifying the most significant indicators and putting in place arrangements to ensure that these are documented and managed consistently would enhance oversight.

- The approach to identifying actions and performance indicators which have fallen out of the scope of monitoring processes, or where performance indicators are not assigned to an owner, is not comprehensive. Introducing exception reporting for this purpose would provide management with greater assurance that actions and indicators are receiving appropriate attention.

- Automated reminders for overdue actions are configured such that they no longer send once an action is more than 30 days overdue. If possible, updating the configuration of the system such that reminders are sent until the action is updated would help to ensure that actions are progressed.

Impact on risk register

The Council's Corporate Risk Register, and the Chief Executive's high level Risk Register included, at time of audit, the following relevant risks:

- DCC005 – Governance (Inherent Risk 5x4, Residual Risk 5x2)
- DCC011 – Transformation (Inherent Risk 5x3, Residual Risk 5x3)
- CEHL022 –Transformation (Inherent Risk 5x3, Residual Risk 3x3)

The Pentana system itself, and the scrutiny and reporting processes that it facilitates, are identified within risk registers as controls which contribute to ensuring that Council Governance remains effective, and that performance and transformation objectives are achieved.

Our review found that, in general, the processes which are in place work well, however there are instances in which the processes themselves are not formally defined. Primarily, processes represent implementations of systems of control by various levels of management for their own particular purposes, and at different levels of scale. Accordingly, the risk represented by failure of those controls is highly variable – being more significant where they relate to the Council's high level plans, such as the Council Plan and City Plan.

A key benefit of the Pentana system, and the present arrangement whereby Services are able to design and implement their own processes via a dedicated Service administrator, is flexibility. Controls can be tailored to provide a proportionate level of scrutiny appropriate to the plan, project, or other initiative being managed through Pentana.

Though we have recommended formalisation of certain aspects of the processes which underpin the operation of the Pentana system, the scope of these requirements should remain

appropriate to the activity that it is being used to manage. Formalising the approach to the use of the system would provide additional assurance where it is most relevant, while not imposing undue administrative burden on Services and Teams using Pentana to manage local initiatives and lower risk processes.

(ii) INTERNAL AUDIT REPORT 2023/10

Client	**Children and Families Service**
Subject	**Permanence**

Executive Summary

Conclusion

Substantial Assurance
The Children and Families Service has established a framework for permanence planning with effective processes to ensure timely and appropriate actions for looked after children. We have identified areas for improvement relating to data management and milestone tracking. These recommendations will, if implemented, enhance the ability of the Service to monitor progress and demonstrate compliance, and support delivery of better outcomes for looked after children.

Background

Permanence means making a long-term plan for children and young people within the formal care system, which lasts throughout their childhood. There are a range of potential outcomes, inside and outside of the care system:

- keeping children at home with family support;
- returning a child to the family home with continual professional support;
- kinship care, where a child is cared for by another family member;
- long-term fostering;
- residential care or adoption.

Permanence outcomes may be implemented by a court order, such as a Compulsory Supervision Order (CSO), a Residence Order in the case of kinship care, or a Permanence Order. A Permanence Order is a “court order which will regulate the exercise of parental responsibilities and parental rights in respect of children who cannot reside with their parents, but where contact or shared exercise of parental responsibilities and parental rights is, or may be, appropriate.”

The Chief Social Work Officer reported that there were 106 children and young people on Permanence Orders as of the 31st of March 2023, with 28 new Permanence Orders made during 2022-23. Permanence Orders were in place for 25% of children experiencing care at home or away from home in Dundee.

In 2019 the PACE (Permanence and Care Excellence) programme was developed to address delay and drift in children’s planning, with the aim of improving the timescales for decisions experienced by children and young people in the care system. Initially tests of change were implemented for young children and delivered significant improvements, resulting in expansion of the programme in 2021/22 to include over 12s.

Processes for Permanence are fundamental to the delivery of Scottish Government policy initiatives; the Council's objectives to improve outcomes for Care Experienced children and young people; and to the Council's child protection responsibilities.

Scope

High level review of the arrangements in place to support the decision-making process surrounding children being placed in permanent care and ensure compliance with relevant legislation.

Objectives

		Action Priority			
		C	H	M	L
Objective 1: Guidance and Procedures have been developed and implemented which are designed to ensure that the Council complies with its statutory obligations	**Substantial Assurance**	-	-	2	-
Objective 2: All looked after children have a plan for permanence, which is kept up to date	**Substantial Assurance**	-	-	1	-
Objective 3: Plans for looked after children are subject to appropriate oversight and approval	**Comprehensive Assurance**	-	-	-	-
Objective 4: Management information adequate to identify issues and developing risks is regularly compiled and reported	**Substantial Assurance**	-	-	1	-
TOTAL		-	-	4	-

Nature of Recommendations

Three (medium) of the recommendations relate to the design of controls, and one (medium) to the operation of existing controls. This suggests that the control framework itself requires revision to adequately address the risks identified.

Key Findings

We identified a number of areas of good practice:

- The Children and Families Service has implemented a framework for permanence planning, which effectively supports compliance with statutory obligations.
- Training and development programmes cover statutory requirements and internal protocols relating to child protection and permanence planning.
- There is clear commitment to initiating and progressing permanence plans for looked after children, with particularly strong performance in early-stage processes and timelines.

- There are systems in place to ensure that any issues with the implementation of a child's permanence plan are identified promptly.

- Oversight and review mechanisms are embedded throughout the permanence planning process, supporting timely progression and informed decision making for looked after children.

- A data collection, analysis and reporting framework underpin permanence planning, featuring multi stakeholder involvement and regular reviews.

- Using data to make improvements is leading to better results in key areas of permanence planning and shows the service can adapt and respond to needs.

- The service is making improvements at managing information about permanence planning and outcomes for children in care, providing more detailed insights.

We have identified the following areas for improvement:

- We identified issues with document storage and access, making it difficult for staff to follow policies and keep track of decisions, which could affect how well the service follows legal requirements and provides consistent care.

- Milestones relating to interaction with the courts are not consistently recorded.

- System limitations necessitate resource-intensive manual data compilation processes in some areas, impacting efficiency and data integrity.

Impact on risk register

The Dundee City Council Corporate and Service risk registers included, at time of audit, the following risks:

- DCC004a Failure to Adequately Address Poverty / Inequalities (inherent risk 5x4, residual risk 5x3)

- DCC009 Statutory and Legislative Compliance (inherent risk 5x4, residual risk 5x2)

- CFCJ006 Demand-Led Services / Legislation (inherent risk 5x5, residual risk 4x4)

- CFCJ004 Harm (to / caused by service user) (inherent risk 5x5, residual risk 5x3)

The most significant risks identified in the risk register relate to statutory compliance and potential harm to service users. Our review considered these risks from the perspective of timely performance planning and the ability to demonstrate appropriate decision making throughout the process.

A key mitigation against these risks is the permanence planning framework in place. We revealed that the effectiveness of this mitigation is compromised by challenges in accurately tracking court lodging dates and difficulties in accessing key policy documents. These issues could potentially impact the services ability to demonstrate compliance with statutory obligations if required.

The principal risk emerging from our review relates to data management limitations. The service faces significant challenges in extracting meaningful information from the MOSAIC system and maintaining consistent records of key milestones. This impacts the ability to monitor and evidence the permanence journey effectively, which is crucial for both statutory compliance and ensuring timely outcomes for looked after children.

We found that while management is aware of cases that drift beyond expected timelines and makes decisions based on individual needs, the current systems and processes for tracking and reporting on these decisions are not fully mature.

The areas for improvement referenced at paragraph 8 above, if implemented, would help the service better demonstrate its decision-making processes, manage compliance risks and ultimately support better outcomes for looked after children.

(iii) INTERNAL AUDIT REPORT 2023/24

Client	**Children and Families Service**
Subject	**Health and Safety Risk Assessments and Incident Management in Schools**

Executive Summary

Conclusion

Substantial Assurance

The Health and Safety team, in collaboration with the Children and Families Service, has established a framework for health and safety management which includes risk assessment and incident management in schools and nurseries. This framework is underpinned by clear policies & procedures, and well-defined allocation of responsibilities requiring schools/nurseries to develop their own Health and Safety Operational Arrangements. The framework was being rolled out in schools/nurseries during our fieldwork in 2024 and management has confirmed that the roll out has been completed at January 2025.

We found evidence of good practice in incident reporting, risk assessment processes, and communication of health and safety information, largely driven by the Health and Safety team and supported by the central Education Senior Leadership team. While significant progress has been made, we have identified areas for improvement relating to the implementation of training programmes, full adoption of risk assessment practices and consistent implementation of these arrangements across all schools/nurseries.

Our recommendations, once implemented, will support the Children and Families Service in further enhancing the consistency of health and safety practices, improving risk management, and strengthening the culture of safety in educational establishments. These improvements will contribute to the ongoing protection of staff, students, and visitors in Dundee City Council schools and nurseries, building on the solid foundation already established through the collaborative efforts of the Health and Safety team, Headteachers and the central Education Senior Leadership team.

Background

The Council has a statutory responsibility to protect the Health and Safety of employees, individuals using Council services, and the public more generally. The arrangements for meeting this responsibility are set out within the Council's Health and Safety Policy and Management Framework, and the associated Health and Safety Policy Statement.

Services are responsible for the management and control of their own Health and Safety risks, including completion of risk assessments. Heads of Service or Service Managers have delegated responsibility for ensuring that risk assessments are completed, approved, and implemented within their service area and that these assessments are developed into safe systems of work and controls, which are then communicated to relevant individuals within the Service.

Within schools/nurseries, the Head of Establishment (e.g. Headteacher) has specific responsibility for ensuring that appropriate Health and Safety systems are implemented within the facilities for which they are responsible. This includes systems and processes for inspection and risk assessment, implementation of appropriate procedures, and implementation of incident reporting systems.

Scope

Review of the arrangements in place within schools/nurseries to ensure completion of health and safety risk assessments for activities including determination of roles and responsibilities.

Objectives

		Action Priority			
		C	H	M	L
Objective 1: Responsibility for implementing the requirements of the Council's Health and Safety Policy and Management Framework within schools has been appropriately allocated and communicated	**Substantial Assurance**	-	-	1	-
Objective 2: Schools/Nurseries have complied with the risk assessment and inspection requirements of the Health and Safety Policy and Management Framework.	**Substantial Assurance**	-	-	1	-
Objective 3: Appropriate procedures have been implemented within schools/nurseries for reporting and recording of incidents, including notification to the Corporate Health and Safety team.	**Comprehensive Assurance**	-	-	-	-
Objective 4: There are adequate arrangements for the implementation of action identified from risk assessments, inspections, and/or incidents.	**Substantial Assurance**	-	-	1	-
TOTAL		-	-	3	-

Nature of Recommendations

One (medium priority) of the recommendations relate to the operation of existing controls, while two (medium priority) relate to the design of a new control. This suggests that while the control framework is largely in place, it requires full implementation of existing controls and the addition and operation of new controls to adequately address the risks identified.

Key Findings

The Children and Families Service, with support from the Corporate Health and Safety team, is currently transitioning to enhanced health and safety management arrangements, with new

operational documentation and processes being implemented across schools and nurseries. This includes consolidating risk assessments, standardising procedures and developing training programmes. While existing health and safety measures remain in place, these changes aim to strengthen and streamline the overall approach to health and safety management in educational settings.

At the time of our review, the new Health and Safety Operational Management Arrangements were being rolled out across schools and nurseries in line with the planned implementation schedule. While some documentation was still pending final approval during our fieldwork, management has since confirmed that the rollout has been completed as planned. As implementation has progressed as intended, no recommendation has been made in this area.

We identified a number of areas of good practice:

- There is a framework in place for allocating and communicating health and safety responsibilities in schools/nurseries, however the effectiveness of these relies on consistent implementation.

- Clear processes and documentation are in place to disseminate health and safety information throughout the school/nursery system.

- Requirements for conducting and reviewing risk assessments are outlined and followed.

- Actions arising from school inspection processes, including internal health and safety audits, external inspections by bodies such as Health and Safety Executive (HSE) and Scottish Fire and Rescue Service (SFRS), and regular checks by locality support officers are consolidated, tracked, and consistently acted upon.

- Procedures for reporting and recording incidents in schools/nurseries, including how to notify the Corporate Health and Safety team are laid out in several documents, supporting understanding at all staff levels.

- Incident reporting practices across schools/nurseries show a high level of compliance with identified requirements.

- Action plans detailing health and safety management arrangements are in place, featuring provisions for review and update to support continuous improvement.

- Regular discussion of health and safety matters in various school meetings shows an embedded culture of safety awareness and ongoing attention to these issues.

We have identified the following areas for improvement, which are already being addressed by the planned changes.

- While there are plans to improve and standardise health and safety training, the planned training programme is not yet fully implemented.

- Risk assessment practices in schools/nurseries are developing, but current compliance rates indicate room for improvement.

- Implementation of Health and Safety Operational Arrangements (HSOA) in schools/nurseries is progressing systematically with plans in place to complete rollout across all establishments.

The actions to implement the recommendations involve every Educational property and the training of the relevant staff within them. The timescales identified for completion of the actions reflect the resources required to deliver and implement the arrangements.

Impact on risk register

The Dundee City Council Corporate risk register, and the Children and Families risk register included, at time of audit, the following risks:

- DCC006 Corporate Health & Safety (inherent risk 5x3, residual risk 4x3)
- CFED005 Health & Safety (inherent risk 5x5, residual risk 5x3)
- CFED011 Statutory / Regulatory Compliance (inherent risk 5x5, residual risk 5x3)

The most significant risks identified in the risk register relate to health and safety compliance and statutory/regulatory compliance. Our review considered these risks from the perspective of implementing health and safety policies, conducting risk assessments, and managing incidents in schools/nurseries.

Key mitigations against these risks include the Health and Safety Policy and Management Framework, individual service health and safety procedures, and risk assessments. Our review revealed that while these mitigations are in place, their effectiveness is somewhat compromised by inconsistent implementation across schools/nurseries and incomplete documentation in some areas.

Our review of the relevant risks (DCC006, CFED005, CFED011) found that the current risk ratings and control effectiveness assessments accurately reflect the environment. Relevant internal controls are appropriately assessed as fully effective, with only those relating to policy, training and risk assessment implementation marked as partially effective. No additional risks were identified that are not already captured in the risk registers.

(iv) INTERNAL AUDIT REPORT 2024/03

Client	**Corporate and City Development**
Subject	**Tay Cities Region Deal**

Executive Summary

Conclusion

Substantial Assurance
The Partnership has implemented robust processes to assess delivery of objectives and outcomes relating to benefits realisation committed to by its constituent Programmes, Fund and Projects. Its ability to measure and clearly communicate those outcomes has been limited in places, where projects have not fully complied with requirements to provide monitoring information.

Background

The Tay Cities Region Deal (the Deal) is a programme of investment to deliver economic growth across the region. The Tay Cities partnership comprises Dundee City, Angus, Perth & Kinross, and Fife councils; the Higher and Further Education sectors; the business sector; Tactran; VisitScotland; the region's third sector interface bodies; Scottish Enterprise and Skills Development Scotland.

The Scottish and UK governments have each agreed to invest up to £150 million in the Deal. This investment has the potential to secure over 6,000 jobs and leverage £400 million of investment over 15 years. It will enable the region to "empower and promote inclusion", "innovate and internationalise" and "connect". The Deal was signed on 17 December 2020.

The Tay Cities Region Deal Grant Offer terms are issued by the Scottish Government annually and signed by the Chief Executive of Dundee City Council, as the Accountable Body, on behalf of the Tay Cities Region Deal. The terms require that the Deal "should be subject to an audit, forming part of the Accountable Body's Risk Based Internal Audit Plan every second year as a minimum."

The Dundee City Council Internal Audit Service has carried out two reviews of the Deal. These took place in 2020/21 (Year 1), covering the developing governance structures and processes for approval of business cases and monitoring of project implementation; and 2022/23 (Year 3), comprising a high level review of progress with Tay Cities Region Deal projects and compliance with grant offer guidance.

In 2024/25 (Year 5) a number of projects within the Deal programme have progressed to implementation. Accordingly, the workload of the Tay Cities Region Deal Joint Committee and Management Group is increasingly shifting, from scrutiny and approval of proposals and business cases, to monitoring delivery of outcomes and benefits arising from projects already approved. To this end the Joint Committee has approved a Benefits Realisation Plan and underpinning reporting process.

Scope

Review of processes for monitoring and reporting benefits realisation, including assessment of their contributions towards Deal outcomes.

Although these processes are supported by the Programme Management Office (PMO), the review will consider the extent to which the Partnership is achieving these objectives.

Objectives		Action Priority			
		C	H	M	L
Objective 1: The Benefits Realisation Plan is consistent with the objectives of the Deal as a whole and the previously approved business cases of individual projects	**Comprehensive Assurance**	-	-	-	-
Objective 2: Monitoring processes for overseeing individual projects require that adequate information is provided to support scrutiny of benefits realisation, including an assessment of the extent to which projects are complying with this requirement	**Substantial Assurance**	-	-	-	-
Objective 3: There is a defined approach to the compilation of benefits realisation information which ensures that information is comparable across projects, and can be linked to Deal outcomes	**Comprehensive Assurance**	-	-	-	-
Objective 4: Benefits realisation information is consistently reported to the management and/or governance group and appropriate action taken where required	**Substantial Assurance**	-	-	1	-
TOTAL		-	-	1	-

Nature of Recommendations

A single recommendation is raised in this report, which relates to the design of reporting controls as opposed to their operation in practice.

In this report, we have raised recommendations where the associated action is within the remit of the Partnership and its officers to implement. We have identified some areas in which action is required on the part of the projects and their lead partner organisations to fully mitigate risks and noted the work that the PMO is carrying out to ensure that these are addressed.

Key Findings

We identified a number of areas of good practice:

- The Partnership has articulated an approach to monitoring the realisation of project benefits, and evaluation of project outcomes. This takes the form of a Benefits Realisation Plan and an underpinning set of processes which set clear reporting requirements for projects, such that they support reporting for the programme as a whole.

- The PMO is a member of the Benefits Realisation Sub-group of the National PMO Networking Group, which shares best practice between Regional Deals across the UK.

- Benefits Realisation monitoring processes consider project and programme outcomes in the same terms as those for business case development and approval, meaning that there is a clear link between the contribution of individual projects and the objectives of the Deal as a whole.

- The monitoring and evaluation approach includes benefits which are common to all projects, and broader outcomes, each of which are subject to appropriate arrangements. The approach is consistently articulated across all relevant deal documentation.

- Definitions for measurement of benefits and outcomes are clearly established.

- There is a robust approach to tracking and reporting project commitments, including approved variations.

- The reporting cycle proceeds according to an established timetable of engagement with projects and programmes, which has been updated for 2023/24.

We made the following observations in relation to arrangements within projects. The remit of internal audit under which this report has been prepared does not extend to the management arrangements within the projects themselves, and therefore we have not raised formal recommendations. In general, these reflect matters which we understand have already been communicated to the Partnership, and that steps are being taken to address them with individual projects.

- Monitoring and reporting processes require that projects explain their approach to measurement of benefits. This is not always clearly expressed in monitoring returns, though we found that in the course of surveying a sample of projects, we were generally able to obtain this information.

- Not all projects have clearly established baselines against which to measure delivery of their commitments. Where relevant, this has been communicated to the projects and Partners concerned and the PMO intends that this will be addressed in future reporting cycles.

- Not all projects we surveyed could clearly explain how benefits realisation reporting and monitoring of outcomes would continue after the end of the active phase of the project. Projects have committed to a period of monitoring which may extend beyond the life of project delivery, and where this is the case, it is necessary for projects to put in place adequate arrangements to collate and report information to support performance reporting for the Deal as a whole.

We have identified the following area for improvement:

- The format of benefits reporting used for the 2022/23 reporting cycle does not clearly explain whether benefits delivery is on track. This is in part a consequence of gaps in the information received from projects and Partners. Lead Partners for each Programme, Fund and Project should provide the appropriate information required for benefits reporting. The PMO should report against the delivery profile information that has been made available so that it is clear whether or not individual projects are delivering benefits and outcomes in line with expectation. Where the appropriate information has not been provided, this should also be made clear.

Impact on risk register

The Tay Cities Region Deal risk register included, at time of audit, the following risks:

- Inflation and Increased Project Costs (score 25)

- Failure to deliver individual Fund/Programmes and Projects within the TCRD programme (score 16)

The highest rated risks within the programme risk register continue to be those which pertain to the viability of projects and the likelihood of their delivering the outcomes which formed the basis of the business case for which funding was awarded.

While this report raises only one recommendation, it includes a number of observations in regard to the ability of projects and their lead partner to demonstrate that they are fulfilling the objectives and outcomes that they committed to deliver. If the Partnership is not able to demonstrate that these objectives can be delivered, this presents a risk to the ability of the partners and the region to attract funding in the future.

We have raised a recommendation that relates to the way in which progress in the achievement of outcomes and delivery of benefits is reported. Better quality information from projects will enable the PMO to report to the Partnership in a way that supports scrutiny of the degree to which projects and their lead partner are fulfilling their commitments.

(v) INTERNAL AUDIT REPORT 2023/22

Client	**Corporate and Corporate Services**
Subject	**Financial Forecasting**

Executive Summary

Conclusion

Substantial Assurance
The Council's processes for the preparation and reporting of forecast outturns were found to be generally well-designed. The Revenue Budget Control Manual is in the process of being reviewed at the time of the audit. We noted a number of instances of non-compliance with these processes at the Service area level for example, the Revenue Monitoring templates had not always been submitted in a timely manner, actual spend information from the general ledger used for forecasting in the monitoring reports submitted by the Services is often taken before the month-end close has been done, and the Service areas' explanations for key assumptions and any changes to projections were found to be inadequate in some instances. There is therefore an increased risk that some reported figures are not as accurate and up to date as they could be which may hinder the monitoring and reporting process. At the corporate level, we found that the information regularly reported by the Corporate Finance team to the Council Leadership Team and the City Governance Committee included detail of the assumptions underpinning budgets and forecast outturns, as well as generally sufficient information on other aspects of the Council's financial performance. We have made recommendations predominantly at the Service area level, in relation to the improvements required in financial forecasting. If implemented, these will enhance the controls over this area.

Introduction

Financial forecasting is a core component of financial management and is one of the key processes specified in the Financial Management Code, published by the Chartered Institute of Public Finance and Accountancy (CIPFA). The Code is designed to support good practice in financial management and to assist local authorities in demonstrating their financial sustainability. It does this by setting out the principles by which authorities should be guided in managing their finances, and the specific standards that they should - as a minimum - seek to achieve.

Background

In its accounts for the financial year 2022/23, the Council reported a deficit on provision of services, leading to a net decrease in usable reserves of £5.2m. In the intervening time, funding pressures on Local Authorities have only become more intense. In light of those pressures and the funding settlement for 2023/24, the Policy and Resources Committee (now

the City Governance Committee) approved budgetary savings totalling nearly £5.4m to achieve a balanced budget.

The development of budgets necessitates the selection of assumptions about the financial environment in which the budget will be delivered, including factors outside the Council's direct control - such as interest rates, market prices, and national government policy. New information coming to light may mean that those assumptions must be updated, and the effects of those changes analysed and understood to inform effective financial decision making.

To achieve the planned budget outturn and support the delivery of the Council's Financial, Strategic, and Operational objectives, it is essential that there are robust processes for the preparation of accurate and reliable forecasts of financial outturn.

Scope

This audit comprised a high level review of the control framework in place to support the development of financial forecasting corporately and within service areas.

Objectives

		Action Priority			
		C	H	M	L
Objective 1: Collation of information from Services for the purpose of compiling and comparing financial outturn forecasts is effective.	**Substantial Assurance**	-	-	-	1
Objective 2: Financial monitoring procedures include the preparation of a forecast outturn at Service level, and this is performed, and the outcomes reported on a consistent basis across Services.	**Substantial Assurance**	-	-	3	-
Objective 3: Key financial assumptions underpinning budgets at the Corporate and Service level are documented and reviewed throughout the year to ensure they remain valid.	**Limited Assurance**	-	1	-	-
Objective 4: There are adequate arrangements for reporting and escalating significant movements in assumptions or outturn forecasts.	**Substantial Assurance**	-	-	-	-
TOTAL		-	1	3	1

Nature of Recommendations

Three of the five recommendations made relate to issues identified with the design of existing controls and represent instances in which the control framework requires revision to adequately address risks. The remaining two recommendations relate to the operation of the controls.

Key Findings

We identified the following areas of good practice:

- The process for ensuring that relevant, accurate, and complete information feeds into the monthly forecast outturns prepared and submitted by the Service areas to Corporate Finance was found to be well-designed.

- The Corporate Finance team issues a timetable and Revenue Monitoring template to all Service Areas to assist in ensuring consistency and adequate financial forecasting.

- Corporate Virements were supported by relevant forms and evidence of authorisation by email.

- Key assumptions underpinning forecast outturns at the corporate level are sufficiently documented in the reports sent to Corporate Leadership Team (CLT) / Committee for their scrutiny.

We have identified the following areas for improvement:

- The Revenue Budget Control Manual is out of date and in need of review, updating and formal approval.

- Month end closure timetables need to be reviewed to reduce the impact of timing on significant differences between the actual spend figures reported in the Revenue Monitoring outturns to CLT / Committee and actual expenditure recorded in the general ledger.

- Monthly returns had not been submitted in a timely manner for all months examined and narrative and explanations provided by Service Areas could be improved.

- Key assumptions had not been sufficiently documented within Service Area submissions along with the rationale for any changes to projections.

Impact on risk register

The Council's Corporate and Service risk registers include the following risks relevant to this review:

- DCC001 Financial Sustainability (inherent risk 20, residual risk 20)
- CSCF009 Finance – Planning (inherent risk 25, residual risk 20)
- CSCF010 Finance – Management (inherent risk 25, residual risk 20)

Failing to conduct thorough reviews to ensure reported data aligns with the ledger, inadequately documenting assumptions, and narratives, missing submission deadlines, and not updating the procedural manual can significantly undermine the effectiveness of controls intended to mitigate risks related to financial sustainability, planning, and management.

(vi) INTERNAL AUDIT REPORT 2024/09

Client	**Corporate Services - Corporate Finance**
Subject	**Purchase to Pay**

Executive Summary

Conclusion

Substantial Assurance
Purchase to pay processes are generally sound, with the majority of expected controls integrated into the operation of purchasing systems. We found that controls could be strengthened by better defining the scope of permitted exceptions to core purchasing processes, and by reinforcing understanding of the purpose of key controls among operational staff with responsibility for purchasing.

Background

Purchase to Pay (P2P) is an integrated system that automates the entire process of purchasing goods and services for a business, covering everything from the initial requisition of goods to the final payment to the vendor.

The Council implemented the Purchase to Pay system to enhance the efficiency and control of procurement and payment activities. This process enforces a “No Purchase Order, No Pay” policy, ensuring that all invoices are matched to authorised purchase orders before payment is made.

The system relies on the support of the Purchasing and Creditors modules within Civica, involving the creation and approval of purchase orders, followed by the logging, and matching of invoices, in order to streamline workflows, reduce errors and improve financial control. While automated controls are embedded throughout the process, some aspects still require manual oversight including the generation of management information.

The system handles significant transaction volumes with the Council handling over 8,000 invoices a month during the first four months of 2024/25. The Council aims to pay suppliers within specified terms of 30 days, or 14 days for suppliers within Dundee.

Scope

Review of expenditure processes following the implementation of purchase to pay.

The review will consider the availability of data within the systems to inform development of continuous auditing of purchasing data in future.

Objectives

		Action Priority			
		C	H	M	L
The "No Purchase Order, No Pay" policy is consistently enforced in accordance with Council Guidance.	**Substantial Assurance**	-	-	1	-
Payments are accurately matched to authorised purchase orders and goods or services are appropriately receipted.	**Substantial Assurance**	-	-	2	1
Key controls such as segregation of duties and approval workflows are functioning effectively to prevent fraud and ensure compliance with procurement policies.	**Comprehensive Assurance**	-	-	-	-
Relevant data is accurately compiled, monitored and reported to support effective financial management and decision-making.	**Comprehensive Assurance**	-	-	-	-
TOTAL		-	-	3	1

Nature of Recommendations

Two (both medium) of the four recommendations made relate to issues identified with the design of existing controls and represent instances in which the control framework requires revision to adequately address risks. The remaining two recommendations relate to the operation of the existing controls.

Key Findings

We identified a number of areas of good practice:

- There are adequate controls within the purchasing system to ensure no payment is made without a valid Purchase Order.
- Key policies and procedures are documented and available to staff, which define responsibilities for raising and authorising orders, receiving goods and services, invoice checking, processing and making payments.
- There are adequate controls to ensure payments are matched with an authorised Purchase Order.
- Conventional purchasing controls, including segregation of duties, are integrated into the operation of the Civica Purchasing system and enforced according to unique user credentials.
- Periodic review of user access is carried out; however, a more formal process is in the course of being implemented.

- Reporting requirements are defined in process documentation.

We have identified the following areas for improvement:

- The list of exceptions to 'No Purchase Order No Pay' should be clarified and made available to payment processing staff, and the use of exceptions should be periodically reviewed. We found that a significant proportion of payments excepted from the policy were made under an open-ended exception, meaning the rationale for its use is unclear.

- Guidance should be introduced to establish a consistent approach to receipting invoiced items for payment. Existing Guidance requires only that receipt is recorded through the Civica system; however, we found inconsistent approaches to verifying receipt, and inconsistent understanding of the purpose of confirming receipt.

- Long Outstanding Orders that have not been invoiced remain in the system without being cleared. We understand that a process is being implemented to review and clear outstanding orders as part of the year end process.

Impact on risk register

The (Service) risk register included, at time of audit, the following risks:

- DCC013 Fraud & Corruption (inherent risk 4x5, residual risk 4x3)
- CSCF007a Procurement – General (inherent risk 5x5, residual risk 5x3)
- CSCF008 Compliance (inherent risk 5x5, residual risk 5x3)
- CSCF011 Fraud & Corruption (inherent risk 5x5, residual risk 4x3)

The process of Purchase to Pay is intended to mitigate the risk that the Council is exposed to elements of Fraud & Corruption, Procurement, and Compliance risk. By implementing robust monitoring, oversight, and system controls, the Purchase to Pay process plays a crucial role in mitigating these risks.

The internal controls identified against these risks in the Corporate and Service risk registers consist of:

- "No Purchase Order, No Pay" policy
- Centralised procurement function.
- Segregation of duties
- General monitoring and reporting controls
- Procurement / Supplier controls

We have identified areas for improvement in relation to the exceptions to the 'No Purchase Order No Pay' Policy. We acknowledge that work is underway to finalise process documentation on user access controls within the procurement system and complete a comprehensive user access review.

Risk owners should consider whether risks remain accurately scored in the light of the findings of this review.

Definitions of Levels of Assurance

Comprehensive Assurance	The system of controls is essentially sound and supports the achievement of objectives and management of risk. Controls are consistently applied. Some improvement in relatively minor areas may be identified.
Substantial Assurance	Systems of control are generally sound, however there are instances in which controls can be strengthened, or where controls have not been effectively applied giving rise to increased risk.
Limited Assurance	Some satisfactory elements of control are present; however, weaknesses exist in the system of control, and / or their application, which give rise to significant risk.
No Assurance	Minimal or no satisfactory elements of control are present. Major weaknesses or gaps exist in the system of control, and / or the implementation of established controls, resulting in areas of unmanaged risk.

Definitions of Action Priorities

Critical	**Very High-risk exposure to potentially major negative impact** on resources, security, records, compliance, or reputation from absence of or failure of a fundamental control. Immediate attention is required.
High	**High risk exposure to potentially significant negative impact** on resources, security, records, compliance, or reputation from absence of or non-compliance with a key control. Prompt attention is required.
Medium	**Moderate risk exposure to potentially medium negative impact** on resources, security, records, compliance or reputation from absence or non-compliance with an important supporting control, or isolated non-compliance with a key control. Attention is required within a reasonable timescale.
Low	**Low risk exposure to potentially minor negative impact** on resources, security, records, compliance, or reputation from absence of or non-compliance with a lower-level control**, or areas without risk exposure but which are inefficient, or inconsistent with best practice.** Attention is required within a reasonable timescale.

ITEM No …6……..

REPORT TO: **SCRUTINY COMMITTEE - 23 APRIL 2025**

REPORT ON: **INTERNAL AUDIT PLAN UPDATE AND PROGRESS REPORT**

REPORT BY: **CHIEF INTERNAL AUDITOR**

REPORT NO: **127-2025**

1.0 PURPOSE OF REPORT

To submit to Members of the Scrutiny Committee an update on the progress towards delivering the 2024/25 Internal Audit Plan; the audits from previous years' plans that were not complete in June 2024; information about the number of open internal audit recommendations, progress towards implementing the new Global Internal Audit Standards as they apply to the UK Public Sector (GIAS (UK Public Sector); and the annual report on the activities of the Scottish Local Authority Chief Internal Auditors' Group.

2.0 RECOMMENDATIONS

It is recommended that the Committee note:

(i) the progress with the Internal Audit Plan;

(ii) progress with the implementation of agreed internal audit recommendations;

(iii) progress with implementation of the GIAS (UK Public Sector) compliance action plan; and

(iv) the Scottish Local Authority Chief Internal Auditor's Group (SLACIAG) annual report.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 AUDIT PROGRESS

4.1 Appendix 1 notes the current stage of progress with implementing the 2024/25 Internal Audit Plan and the outstanding items brought forward from the 2022/23 and 2023/24 Plans (the plan).

4.2 One new audit on Housing Stock (External Wall Insulation) has been added to the plan as reported at the Neighbourhood Regeneration, Housing and Estate Management Committee on 20 January 2025 (Item 5 Exempt report 31-2025). The audit work is at the review stage and was undertaken by the audit support contractor.

4.3 Two audits have been removed from the plan because the proposed scope would duplicate work already underway within the services. Both areas remain in the audit universe and will be considered for audit again in future.

- The review of the arrangements to implement and oversee the next phase of the Fairness and Local Child Poverty Action Plan, and
- The review of the processes to plan and carry out maintenance on Council housing stock, including arrangements for reactive maintenance.

4.4 Appendix 2 shows the open internal audit recommendations by service, audit year and risk priority. Progress has continued to implement actions, with seven actions closed since this was last reported in February 2025. Twenty-five actions have past their due date and require a new target date to be set by the services.

Global Internal Audit Standards (GIAS) (UK Public Sector) Update

4.5 GIAS (UK Public Sector) replaces the Public Sector Internal Audit Standards (PSIAS) from 1 April 2025.

4.6 To prepare for this change a gap analysis between the requirements of the GIAS (UK Public Sector) and the PSIAS was undertaken and an action plan prepared. The action plan (Appendix 3) is currently being worked through. The expectation is that compliance will be achieved during the first year of the new standards applying, with the final element to be implemented relating to annual reporting in June 2026.

4.7 The Internal Audit Strategy, and the Mandate and Charter being presented to this April meeting of the Scrutiny and Audit Committee in Report 129/25 are part of the action plan implementation.

Scottish Local Authority Chief Internal Auditor's Group (SLACIAG) 2024 Annual Report

4.8 Appendix 4 is the 2024 annual report from the Chair of SLACIAG, summarising the work undertaken by the group for the year and demonstrating the support provided for the Chief Internal Auditor and the wider Internal Audit and Counter Fraud teams.

4.9 There are a number of sub-groups that take forward topics of particular interest and risk and members of the Council's teams participate in the counter fraud, computer audit and resources groups.

5.0 POLICY IMPLICATIONS

This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services, or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6.0 CONSULTATIONS

The Council Leadership Team have been consulted in the preparation of this report.

7.0 BACKGROUND PAPERS

The following background papers, as detailed by Section 50D of the Local Government (Scotland) Act 1973 (other than containing confidential or exempt information) were relied on to a material extent in preparing the above report.

The Global Internal Audit Standards issued January 2024
The Application Note; Global Internal Audit Standards in the UK Public Sector - issued December 2024, and
Cipfa's Code of Practice on the Governance of Internal Audit - issued February 2025

Appendix 1 - 2022/23, 2023/24 and 2024/25 Internal Audit Plan update.

Appendix 2 - Outstanding Internal Audit Agreed Actions.

Appendix 3 - GIAS (UK Public Sector) Action Plan

Appendix 4 - SLACIAG Annual Report 2024

CATHIE WYLLIE, CHIEF INTERNAL AUDITOR **DATE: 2 APRIL 2025**

Completed items

2022/23 and 2023/24 Internal Audit Plan - Progress Report (Audits completed after June 2024)

2022/23 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level
Governance Reviews				
Staff Wellbeing/Absence Management (Contractor)	Review of the governance arrangements in place throughout the Council to promote and support staff wellbeing. The scope of this audit will pick up some elements of the absence management audit removed from the plan.	December 2024	Complete	Limited
ICT Reviews				
Microsoft Office 365 (Contractor)	Review of access permissions and licensing arrangements for Office 365 including linking to management of network access.	December 2024 Revised to June 2025	Draft report issued 7/6/24 various discussions and further evidence provided latest draft issued 28/3/25	
Civica CX – Rent Accounting Module	Review of the arrangements for the implementation of Phase 1 of Civica CX incorporating Housing Rent collection and recording of Housing Benefit/Universal Credit housing costs.	February 2025 Revised to June 2025	Draft report issued 2/4/25	
User Access Management (Contractor)	High level review of the appropriateness of user access levels and associated permissions for Civica Financials and Purchasing systems.	December 2024	Complete	Limited

APPENDIX 1

2022/23 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level
		Revised to February 2025		
Systems Reviews				
Health and Safety - Incident Reports	Review of the Council's arrangements for the recording and reporting of Incident Reports.	September 2024	Complete	Substantial
Procurement / Contract Reviews				
Social Work Contracts and Payments	Review of contract management and commissioning arrangements, including payments, within Dundee Health and Social Care Partnership to assess their adequacy and effectiveness.	February 2025 Revised to September 2025	In progress	

2023/24 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level
Governance Reviews				
Absence Management	Review the arrangements in place within the Council to mitigate long term and future absence arising from sickness absences.	December 2024	Joint with Staff Wellbeing above Complete	Limited
Corporate Governance	Review of elements of the Annual Corporate Governance checklist with service areas to demonstrate evidence of compliance.	December 2024	Complete	Substantial

APPENDIX 1

2023/24 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level
Financial Reviews				
Corporate Debt Recovery Arrangements	Corporate wide review of the Council's debt management and debt recovery arrangements.	December 2024 Revised to February 2025	Complete	Limited
Financial Forecasting (Contractor)	High level review of the control framework in place to support the development of financial forecasting corporately and within service areas.	December 2024 Revised to April 2025	Complete	Substantial
Procurement / Contract Reviews				
SLAs with External Bodies	Assess the extent to which the Council has adequate service level agreements in place where Council responsibilities are delivered by external bodies. To include an assessment of arrangements to ensure satisfactory service delivery and value for money.	April 2025 Revised to June 2025	In progress	
System Reviews				
Health and Safety Risk Assessments and Incident Management in Schools	Review of the arrangements in place within schools to ensure completion of health and safety risk assessments for activities including determination of roles and responsibilities.	February 2025 Revised to April 2025	Complete	Substantial
Section 75 Planning Obligations (Contractor)	Review of the arrangements in place for the recording, receipt, and monitoring of Section 75 payments/planning obligations from Developers.	February 2025 Revised to June 2025	Draft report issued 12/11/24	

APPENDIX 1

2023/24 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level
Safety Alarm Response Centre	To assess the arrangements for the operation of the Safety Alarm Response Centre (SARC) in line with the Council's Resilience and Community Safety plans.	December 2024	Complete	Limited
Pentana	Review of the Council's Performance and Risk Management system in terms of management reporting and efficiencies.	December 2024 Revised to April 2025	Complete	Substantial
Permanence	High level review of the arrangements in place to support the decision-making process surrounding children being placed in permanent care and ensure compliance with relevant legislation.	December 2024 Revised to April 2025	Complete	Substantial
Recruitment (Contractor)	Review of the Council's Recruitment and Selection approach, including reporting and analysis of effectiveness, and identification of actions where required.	December 2024	Complete	Substantial
Young People in Residential Care - Missing Persons Processes	Review of the arrangements for risk assessment, planning for, and prevention of young people going missing from Residential Care. To include review of processes for identifying, recording, and responding to such instances.	April 2025 Revised to September 2025	In Progress	

APPENDIX 1

2024/25 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level
Governance Reviews				
Child Poverty and Fairness Action Plan	Review of the arrangements to implement and oversee the next phase of the Fairness and Local Child Poverty Action Plan, including measurement of progress towards Scottish Government targets.	April 2025	Propose to Remove (conflicts with work taking place within Service)	
Partnership Working - Dundee Alcohol and Drugs Partnership	Review of the arrangements which underpin the Council's delivery responsibilities under the Alcohol and Drugs Partnership's Strategic Framework, including delivery plans, progress monitoring, and engagement with other members of the Partnership.	April 2025 Revised to September 2025	In Progress	
Tay Cities Deal	The Grant Offer Letter provided to Dundee City Council as lead authority for the deal requires that the Authority's Internal Audit Service performs a review of arrangements to implement and oversee the deal at least every other year. This year's audit will be a review of the benefits realisation processes including assessment of benefits towards delivering outcomes.	February 2025 Revised to April 2025	Complete	Substantial
Risk Management	A review of the Council's risk management processes will be carried out by the Internal Audit contractor.	June 2025	Draft report in review	
ICT Reviews				
End User Computing - Cloud Migration	A critical friend review of the processes in place to manage end user device access to the Council's network and applications. There have been changes to how people work and the devices they use. From a security perspective, it is vital that only authorised devices are permitted access to Council systems and data.	June 2025	Propose to remove (replaced with Service Cyber Incident Readiness)	

2024/25 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level
User Access Management	The review will consider the adequacy of user access management controls for the Northgate application. This will include assessment of the processes for joiners, movers, and leavers as well as access management arrangement to achieve segregation of duties, and monitoring of privileged accounts.	June 2025	Draft report in review	
Service Cyber Incident Readiness	Review the adequacy of design, and operating effectiveness of key controls, established in services to ensure delivery of their key activities to a minimum agreed level, during a cyber incident.	September 2025	Planning	
Financial Reviews				
Capital Planning and Monitoring	Review of the procedures to oversee the implementation of Capital Plans, in line with the Council's Capital Investment Strategy, and monitor and scrutinise Capital expenditure.	February 2025 Revised to June 2025	In review	
Payroll - Changes in Circumstances	Review of the processes by which information affecting individual's pay calculation is notified and actioned. To include pension contributions and salary sacrifice schemes.	February 2025 Revised to June 2025	In Review	
Purchase to Pay	Review of expenditure processes following the implementation of purchase to pay. To include consideration approaches to support continuous auditing of purchasing data.	February 2025 Revised to April 2025	Complete	Substantial
MOSAIC system payments	Review of payment processes added mid-year at Service's request.	April 2025	In progress	

2024/25 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level
		Revised to June 2025		
Systems Reviews				
Asset Management	Review of the processes which ensure that the Council's asset management databases are complete, accurate, and kept up to date. To include processes for condition assessment.	February 2025 Deferred to 2025/26	Deferred	N/A
Housing - Planned and Reactive Maintenance	Review of the processes to plan and carry out maintenance on Council housing stock, including arrangements for reactive maintenance.	April 2025 Revised to June 2025	Propose to Remove (conflict with work underway within Service)	
Immigration Sponsorship and Visas	Review of the processes by which the Council considers and manages recruitment applications from individuals overseas and/or requiring visa sponsorship, including the update of these policies and procedures in line with changing legislation.	April 2025 Deferred to 2025/26	Request to delay to 2025/26 from service due to current review of procedures	N/A
Onboarding & Induction	Review of onboarding processes for all staff, and the guidance available to line management overseeing and recording the onboarding of new starts.	Deferred	Removed to reserve list for 2025/26 due to risk assessment	
Multi Agency Safeguarding Hub (MASH) Intake processes	Review of the administrative processes to support the Multi-Agency Safeguarding hub in taking timely, effective action on referrals in collaboration with Council Services and partner bodies.	April 2025 Revised to September 2025	Planning	

2024/25 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level
Climate Strategy and Delivery Plans	Review to be conducted using a scope and audit programme being developed by SLACIAG for use across local authorities in Scotland.	June 2025	In Review	
Insurance	A review of Insurance processes will be carried out by the Internal Audit contractor.	June 2025	Audit Fieldwork complete	
DHSCP Review	Review covering an aspect of DHSCP activity. Scope to be confirmed in consultation with the internal auditors for the IJB.	June 2025	Planning	
Other Work				
Housing Stock (External Wall Insultation)	Review the processes, procedures and programmes relating to the implementation of the works identified as required after August 2021 by the report from the Design & Property Service.	June 2025	In Review	
Follow Up	Review of progress with the implementation of prior internal audit actions agreed by the Council, for the purpose of providing assurance to Elected Members that identified issues are addressed on a timely basis, and that management attention is appropriately directed towards issues which expose the Council to higher degrees of risk.	Each meeting	Ongoing	N/A
Technical Development	Planning and Scoping work for review and update of the Council's Internal Audit Methodology, including the introduction of Continuous Auditing and Data Analytics and implementation of new Public Sector Internal Audit Standards expected late summer/early autumn 2024.	As required. GIAS(UKPS) Action Plan and Strategy April 2025	In Progress	N/A
Advice and Guidance	Provision of ad-hoc support to assist services in respect of specific queries and contribute to the delivery of improvements	N/A	Ongoing	N/A

2024/25 INTERNAL AUDIT PLAN	Proposed Coverage	Target Scrutiny Reporting	Status / Update	Assurance Level
	in the Council's framework of governance, risk management and control. This will include the ongoing provision of advice and guidance surrounding the development ofnewly implemented systems and processes, or the revision and update of those processes.			
External Quality Assessment Process	As part of the peer review process developed to ensure conformance with the PSIAS, complete External Quality Assessment (EQA) of the Council's Internal Audit Service. Self-assessment provided to reviewer November 2023. Review delayed during 2024, re-started in October 2024.	December 2024 Revised to June 2025	Review in progress	
PSIAS Quality Self-Assessment	Annual self-assessment for conformance with PSIAS	June 2025		
Specific Investigations	To respond to requests for advice and assistance as required in respect of cases of suspected fraud, corruption, or malpractice.	As required	On-going as required	N/A

APPENDIX 1

Definitions of Levels of Assurance

Comprehensive Assurance	The system of controls is essentially sound and supports the achievement of objectives and management of risk. Controls are consistently applied. Some improvement in relatively minor areas may be identified.
Substantial Assurance	Systems of control are generally sound, however there are instances in which controls can be strengthened, or where controls have not been effectively applied giving rise to increased risk.
Limited Assurance	Some satisfactory elements of control are present; however, weaknesses exist in the system of control, and / or their application, which give rise to significant risk.
No Assurance	Minimal or no satisfactory elements of control are present. Major weaknesses or gaps exist in the system of control, and/or the implementation of established controls, resulting in areas of unmanaged risk.

OUTSTANDING INTERNAL AUDIT AGREED ACTIONS

Agreed actions from Internal Audit recommendations are recorded in Pentana and implementation is monitored by Services and the Risk and Assurance Board. Implementation of the agreed action is the responsibility of the service area, and the risk exposure identified in the audit remains in place until the action has been completed. New dates should be agreed for actions that were not complete by their original due date.

The numbers of outstanding actions in Pentana for each Service, by audit year, on 25 March 2025 are summarised in the following tables.

- Table 1 - shows actions that have not yet reached their original agreed due date.
- Table 2 - shows actions that have had their due dates extended, but are still not completed.
- Table 3 - shows actions overdue from their agreed due date, and which require a new date to be agreed.

At 25 March 2025 there were 74 open actions, compared to 65 at 14 January 2025. 2 are critical. This represents the closure of 7 actions and addition of 16 new actions. New dates for completion of overdue actions are required for the actions in Tables 2 and 3. There is still work to be done to close off older actions, the majority of which have a high level of completion but still require a little more work to complete fully.

Table 1 - Actions not yet reached original agreed due date

Service	Audit Year	Critical	High	Medium	Low	Total
		No	No	No	No	No
Children and Families	2023/24	-	-	4	-	4
Corporate Services	2022/23	-	2	-	2	4
	2023/24	-	2	9	1	12
Neighbourhood Services	2022/23	-	1	-	-	1
Totals		**0**	**5**	**13**	**3**	**21**

Table 2 - Actions with due date extended from original due date

Service	Audit Year	Critical	High	Medium	Low	Total
		No	No	No	No	No
Chief Executives Service	2022/23	2	-	-	-	2
	2023/24	-	2	1	1	4
City Development	2022/23	-	2	-	-	2
Corporate Services	2020/21	-	1	-	-	1
	2021/22	-	1	-	3	4
	2022/23	-	2	3	3	8
Corporate	2021/22	-	1	-	1	2
Neighbourhood Services	2016/17	-	1	-	-	1
	2017/18	-	1	-	-	1
	2020/21	-	2	-	-	2
	2022/23	-	-	1	-	1
Totals		**2**	**13**	**4**	**8**	**28**

Table 3 - Actions overdue from agreed due date

Service	Audit Year	Critical	High	Medium	Low	Total
		No	No	No	No	No
Children and Families	2023/24	-	-	4	1	5
Corporate Services	2021/22	-	-	-	1	1
	2022/23	-	1	2	-	3
	2023/24	-	4	6	3	13
Neighbourhood Services	2023/24	-	3	-	-	3
Totals		**0**	**8**	**12**	**5**	**25**

Definitions of Action Priority

Critical	**Very high-risk exposure to potentially major negative impact** on resources, security, records, compliance, or reputation from absence of or failure of a fundamental control. Immediate attention is required.
High	**High risk exposure to potentially significant negative impact** on resources, security, records, compliance, or reputation from absence of or non-compliance with a key control. Prompt attention is required.
Medium	**Moderate risk exposure to potentially medium negative impact** on resources, security, records, compliance or reputation from absence or non-compliance with an important supporting control, or isolated non-compliance with a key control. Attention is required within a reasonable timescale.
Low	**Low risk exposure to potentially minor negative impact** on resources, security, records, compliance, or reputation from absence of or non-compliance with a lower-level control**, or areas without risk exposure but which are inefficient, or inconsistent with best practice.** Attention is required within a reasonable timescale.

APPENDIX 3

Global Internal Audit Standards (UK Public Sector) compliance action plan

Compliance	Action	Progress 28 March 2025	Responsible Officer	Due Date
Compliance with Cipfa Code on Governance of internal Audit	Review requirements of the Code, raise with Council Leadership Team (CLT), Scrutiny Committee members and Corporate Governance Officers Group and identify actions required for compliance.	The Code was published in February 2025. It was discussed with CLT 11 March 2025, and Elected Members briefings are scheduled for 14 and 15 April 2025 On Target	Chief Audit Executive	30 June 2026
IA Strategy, Mandate and Charter	Create Strategy and Mandate and Charter documents, consult team, CLT, and Scrutiny Committee and take to April Scrutiny committee.	Draft documents preparation included discussion with and input from IA team members, CLT (11/3/25) and Elected Members on Scrutiny committee (14 and 15 April 2025). Draft documents to come to April Scrutiny Committee. Mandate and Charter for approval and Strategy for noting. On Target	Chief Audit Executive	30 April 2025
Audit Planning	Ensure audit planning covers all required aspects of GIAS UK (Public Sector).	Planning requirements of the GIAS (UK Public Sector) reviewed and incorporated into planning for the 2025/26 annual internal audit plan. Draft plan to be approved at April Scrutiny Committee meeting. **Complete**	Chief Audit Executive	31 March 2025
Update Audit Manual and checklists	Review IA Manual checklists and update as necessary for areas where GIAS (UK Public Sector) say procedures are required or we think it would be beneficial. Include EQA procedure. Standards 1.1;1.2; 4.1; 4.3; 5.2;	Initial conformance review undertaken and areas for further action identified. In progress	Chief Audit Executive, Acting Senior Manager, Internal Audit and Senior Auditor	30 June 2025

Compliance	Action	Progress 28 March 2025	Responsible Officer	Due Date
	9.3; 11.1; 11.3; 13.1; 13.2; 14.1; 14.2 14.3; 14.4; 15.1			
Create training log	Create training log for whole IA team Standards 3.1; 3.2	Not started	Chief Audit Executive, Acting Senior Manager, Internal Audit and Senior Auditor	30 June 2025
Skills Audit	Undertake skills/knowledge audit in IA team against core competencies /knowledge areas and consider training needs thereafter. Review job descriptions/ people specs to ensure fully compliant. Standard 3.1	Not started	Chief Audit Executive, Acting Senior Manager, Internal Audit and Senior Auditor	31 August 2025
Root Cause Analysis	Develop approach to identifying Root Cause Analysis in audit planning / audit programme, undertake training in team and apply in audits. Standard 11.3	Initial research begun	Chief Audit Executive, Acting Senior Manager, Internal Audit and Senior Auditor	31 August 2025
Performance Measurement	Review Internal Audit KPIs and update if necessary, creating new data capture mechanisms if needed. Standard 12.2	Not started	Chief Audit Executive, Acting Senior Manager, Internal Audit and Senior Auditor	30 September 2025
Ethics training	Identify and deliver ethics training for IA team. Standard 3.2	Not started – may be covered at SLACIAG conference in June 2025	Chief Audit Executive	31 July 2025
General training	Review GIAS (UK Public Sector) mandated training and deliver training. Also training on updates to manual if required	Initial discussions about the changes have taken place during regular team meetings, including discussion of the draft Strategy, and the draft Mandate and Charter	Chief Audit Executive	31 December 2025

APPENDIX 3

Compliance	Action	Progress 28 March 2025	Responsible Officer	Due Date
CAE Annual Report	Review annual report content to ensure compliance. Also consider what S&A committee should be asked to do with the report	Not started	Chief Audit Executive	16 May 2025
Stakeholder feedback	Review feedback form and update if required Standard 1.1	Not started	Acting Senior Manager, Internal Audit	31 August 2025
Self-assessment GIAS (UK Public Sector) compliance	First annual self-assessment of conformance will be due in 2026 for reporting in June 2026, Interim updates re action plan to go to committee	Not started	Chief Audit Executive	31 May 2026

SCOTTISH LOCAL AUTHORITIES
Chief Internal Auditors' Group

ANNUAL REPORT FROM THE CHAIR - 2024

"WORKING TOGETHER TO SUPPORT THE KEY ROLE OF INTERNAL AUDIT"

1. INTRODUCTION

1.1 Membership of the CIPFA Scottish Local Authorities Chief Internal Auditors' Group (SLACIAG) is open to the chief internal auditor from each Scottish local authority and the Strathclyde Partnership for Transport (SPT). SLACIAG is a Special Interest Group of CIPFA in Scotland, with operational arrangements, vision, and objectives set out in a formal Constitution.

1.2 **SLACIAG's Vision is to be the voice of internal audit across Scottish local authorities and a driving force for best practice in respect of local authority and public transport bodies internal audit, governance, and operations.**

1.3 In support of that **Vision**, SLACIAG has the following **objectives**:

- Secure a quality and responsive service for members of the group.
- Develop the influence of the group with key decision makers and institutions in Scotland, as the key representative body for internal audit in local government with a particular emphasis on governance, risk, control and assurance matters.
- Strengthen links and build long term relationships across the internal audit community within the public service.
- Provide an effective group for the discussion of issues of common concern, sharing of good practice and commissioner of work to develop advanced practice.
- Consider the development and training needs of our people as a collective to ensure that the best available products are procured at the best price.
- Uphold the group's key values, including respect; openness and honesty; adding value; professional team working; sharing best practice; integrity; continuous improvement.

1.4 The purpose of this annual report to key stakeholders is to provide an update on SLACIAG's activities and achievements over the course of 2024 and to recognise actions required to achieve its Vision.

1.5 SLACIAG has two long-established sub-groups whose activity is reflected in this report:

- the Computer Audit Sub-Group (CASG); and
- the Scottish Local Authorities Investigators' Group (SLAIG).

1.6 Further sub-groups were established by SLACIAG in 2023 to lead on development actions arising from the SLACIAG Conference held in June 2023 within specific themes, including risk, data analytics, resourcing, and sustainability/climate change. Their activity in 2024 is also reflected in this report.

2. MANAGEMENT COMMITTEE

2.1 I, Jill Stacey, Scottish Borders Council, was appointed as Chair of SLACIAG at the AGM in March 2024, continuing as Chair following a 2-year term during 2022-2023 to facilitate succession planning within the Management Committee. I previously served as Chair of SLACIAG during 2014-2015. In accordance with SLACIAG's Constitution, my term of office will expire after serving 2 years at the SLACIAG AGM in March 2026. The Chair of SLACIAG joins the meetings of the CIPFA Scotland Branch Executive Committee, as SLACIAG is a special interest group of CIPFA in Scotland.

2.2 Yvonne Douglas, South Lanarkshire Council, was re-elected as Treasurer of SLACIAG at the AGM March 2024 having initially been appointed to the role in June 2020. Yvonne provided regular updates on the financial position of SLACIAG to enable the Management Committee to plan activity.

2.3 The appointments to the SLACIAG Management Committee were approved at the AGM March 2024. New members were welcomed to the Management Committee, including each sub-group Lead to ensure all sub-groups were represented. The Chairs of both CASG and SLAIG participate in the Management Committee meetings to derive benefits from their sectoral expertise and to ensure synergy when forward planning the regular meetings.

2.4 The same membership has continued during 2024, as follows:

SLACIAG MANAGEMENT COMMITTEE 2024		
Jill Stacey	Scottish Borders Council	Chair SLACIAG
Yvonne Douglas	South Lanarkshire Council	Treasurer SLACIAG
Pamela Redpath	Fife Council	Member; Lead for EQA and Risk Sub-Groups
Gillian McConnachie	East Dunbartonshire Council	Member
Duncan Stainbank	East Lothian Council	Member; Lead for Sustainability/ Climate Change Sub-Group
Duncan Black	Glasgow City and Shetland Islands Councils	Member; Lead for Data Analytics Sub-Group
Gordon O'Connor	Stirling Council	Member; EQA Moderation Panel
Jamie Dale	Aberdeenshire and Aberdeen City Councils	Member
Laura Calder	City of Edinburgh Council	Member; Lead for Resourcing Sub-Group
Paul Brown	East Dunbartonshire Council	Chair CASG
Barry Moncur	East Dunbartonshire Council	Chair SLAIG

2.5 There were Management Committee virtual meetings held in April, May, August and October 2024. The purpose of these meetings was to forward plan SLACIAG and Sub-Group meetings, considering topics, setting dates and arranging speakers.

2.6 The Management Committee also oversees the External Quality Assessment (EQA) process, which is a peer review process established by SLACIAG to enable external validation of compliance with the Public Sector Internal Audit Standards (PSIAS). The Management Committee monitors progress with completion against a recommended programme of reviews each year to ensure that all participating organisations comply with the requirement to undertake an EQA once every 5 years.

3. SCOTTISH LOCAL AUTHORITIES' CHIEF INTERNAL AUDITORS GROUP (SLACIAG)

SLACIAG Meetings 2024

3.1 There were four SLACIAG virtual meetings in 2024 with topics/speakers set out in the table below in addition to core business. The network continues to be strongly supported by members with a focus on significant and current issues.

Date	Topics / Speakers
15 March 2024	**AGM** • SLACIAG Annual Report 2023 (Chair) • SLACIAG Constitution (Chair) • SLACIAG Annual Accounts 2023 (Treasurer) • SLACIAG Subscriptions • Election of Officers Bearers **CIPFA Technical Update** • Naomi Whitmore, Public Finance Technical Adviser, CIPFA **Assurance arrangements on Housing Benefit Subsidy Claims in Scotland** • John Cornett, Audit Scotland **Fraud Benchmarking in Scotland - SLAIG** • Barry Moncur, East Dunbartonshire Council, Chair of SLAIG, and Carol Cleland, Renfrewshire Council
7 June 2024	**Director of Finance perspective on Financial Sustainability and the role of Internal Audit** • Jamie Robertson, Executive Officer for Finance & Digital Services, East Dunbartonshire Council (Chair of CIPFA Directors of Finance forum)
20 September 2024	**Strategic Workforce Risks – Best Value area of focus Workforce Innovation** • John Cornett and Blyth Deans, Audit Scotland **Financial Sustainability indicators within LGBF** • Website demo by Emily Lynch, Improvement Service **New Global Internal Audit Standards** • Andrew Paterson, EQA Sub-Group and Orkney Islands Council on behalf of Pamela Redpath, EQA Sub-Group Lead and Fife Council

Date	Topics / Speakers
6 December 2024	**Strategic Workforce Risks – 'Building a Sustainable Scottish Local Government Workforce for the Future' and overview of the Improvement Service "Local Government Workforce Report 2024"** • Amanda Spark, Improvement Service **New CIIA Global Internal Audit Standards (GIAS), IASAB Application Note for GIAS in UK Public Sector, and CIPFA Code of Practice for Governance of Internal Audit in Local Government** • Jill Stacey, SLACIAG Chair and Scottish Borders Council, and Pamela Redpath, EQA Sub-Group Lead and Fife Council

3.2 The Treasurer produced the 2023 annual accounts, which were considered in draft by the Group at the AGM in March 2024. Thanks to those at South Ayrshire Council for completing the independent audit of the 2023 Accounts. Thanks to Yvonne for her professionalism in fulfilling the Treasurer role and providing regular updates during 2024 on the financial position of SLACIAG which is important to ensure the Group remains financially sustainable.

3.3 A report on behalf of the Management Committee was issued to members containing an analysis of the benefits of SLACIAG membership, benchmarking with some other professional bodies' subscription fees, and a proposal on subscriptions for 2025 which was approved.

External Quality Assessment (EQA)

3.4 There continued to be challenges for the completion of the EQA2 schedule including staff resourcing issues in Councils, knock-on effect of delays during the pandemic response and recovery periods, and conflicts of interest arising from increased Internal Audit shared services arrangements. Responsibility is on the reviewee Council CAE to meet EQA requirements and to keep their Audit Committee informed of any delays in meeting the 5-year timeframe.

3.5 The EQA Sub-Group members set out below have been active in 2024 to oversee the completion of the EQA2 schedule and to plan the EQA3 schedule. The draft schedule of EQA3 peer reviews (involves 29 Councils with 21 CAEs due to shared services arrangements) was approved. The vacancy on the Moderation Panel is not deemed to be a significant resourcing issue currently.

EQA Sub-Group		Moderation Panel	
Pamela Redpath	Fife Council	Paul MacAskill	Argyll & Bute Council
Andrew Paterson	Orkney Islands Council	CGordon O'Connor	Stirling Council
Cecilia McGhee	South Ayrshire Council	vacancy	

3.6 The new Global Internal Audit Standards in the UK Public Sector (GIAS), which incorporate the CIIA Global Internal Audit Standards, IASAB Application Note for the UK Public Sector, and CIPFA Code of Practice for the Governance of Internal Audit in Local Government, will have implications for the SLACIAG EQA3 Peer Review Process and Templates. These will be updated by the EQA Sub-Group.

Sub-Groups

3.7 At each of the quarterly SLACIAG meetings during 2024 updates were received from the Sub-Groups in accordance with their respective terms of reference to derive significant benefits from them.

3.8 The **Data Analytics Group** has had four virtual workshops during 2024 coordinated by GCC team. There has been good participation as an opportunity to share practices, insights, data set examples, data analytics strategies, etc. to improve our Digital Skills within our Internal Audit teams and beyond.

3.9 The **Resourcing Group** met virtually three times in 2024 to discuss all matters on resourcing our teams including recruitment, succession planning, training, soft skills, ways of working, and mentoring.

3.10 The **Sustainability / Climate Change Group** shared the Internal Audit Programme on Climate Change Strategy that it had developed, linked to new statutory guidance that is being developed by Sustainable Scotland Network in collaboration with SLACIAG and Audit Scotland on the Role of Audit.

3.11 The **Risk Group** expanded its small membership to share practice within its approved Terms of Reference and to progress risk benchmarking through use of risk management maturity models.

SLACIAG Knowledge Hub

3.12 All Agendas, Minutes, and Presentations of SLACIAG meetings, Conference, EQA Framework Guidance, and other relevant documents are uploaded to the SLACIAG Knowledge Hub to enable access by all members in a secure way. New Members have been registered on the SLACIAG Knowledge Hub, including new starts from within audit teams of Councils, thus enabling greater participation.

4. COMPUTER AUDIT SUB-GROUP

4.1 The main aim of the Computer Audit Sub-Group (CASG), which is a permanent sub-group of SLACIAG, is to provide a forum to share and discuss computer audit practices and developments. This includes raising awareness of new standards, updates to legislation, new and current topics of interest, and computer audit developments, resources, and techniques.

4.2 The Computer Audit Sub-Group (CASG) met two times in 2024, all meetings were virtual, with topics/speakers as follows in addition to core business:

Date	Topics / Speakers
29 May 2024	**Cyber Threats and the Role of a Security Operation Centre (SOC) - A presentation of the current threats that organisations are facing and the importance of having a SOC in mitigating the effects of such attacks.** • Paul Cullimore, Quorum Cyber **Business Continuity Audit – A summary of issues noted as part of a recently completed audit.**

	• Yvonne Trundle, North Ayrshire Council
9 October 2024	**Power BI – A presentation and walkthrough of examples of the uses of Power BI in a Local Authority.** • Hunter Dallas, South Lanarkshire Council **Ransomware Attack, Western Isles Council – Presentation to provide an overview of the attack that occurred in 2023, and any lessons learned.** • Malcolm Nicol, Western Isles Council

4.3 This year has seen a change in the constitution of the Group, with a new Chair and Secretary taking up their roles in the second half of the year, to ensure the sustainability of the sub-group. The participation in the group remains good.

4.4 Within the SLACIAG Annual Report 2023 reference was made to expanding the role and outputs of CASG to cover, for example, Digital Transformation, Artificial Intelligence (AI), and IT/Cyber Security, in addition to core Computer Audit work. This is still under consideration and would involve a change to the Terms of Reference of the Group. In the first instance, 3 topics were suggested:

- Shared Learning from the Western Isles Council from a ransomware attack
- Cyber Security Maturity Assessment – tools and role of Internal Audit
- Contracts via the Local Authority IT Security Group

4.5 The first topic has been covered with an informative presentation given to the group by the Western Isles Council in October 2024. The Group has had discussions with respect to the maturity assessment and further work is planned in 2025, as is increasing communication with the Local Authority IT Security Group. Furthermore, a presentation covering Artificial Intelligence is planned for April 2025.

4.6 Due to the changes in the constitution of the group some Agendas, Minutes, and Presentations for CASG meetings 2024 are still to be uploaded to the SLACIAG Knowledge Hub (CASG sub-folder) to enable access by all members in a secure way. This will be updated in the coming months as well as improving oversight of each Council's ICT audit plans during 2025.

5. SCOTTISH LOCAL AUTHORITY INVESTIGATORS GROUP (SLAIG)

5.1 The main aim of the Scottish Local Authority Investigators Group (SLAIG), which is a permanent sub-group of SLACIAG, is to provide a forum to share and discuss counter fraud practices and developments. This includes raising awareness of updates to legislation, new and current topics of interest, and developments in counter fraud activities.

5.2 The Scottish Local Authority Investigators Group (SLAIG) met four times in 2024, all meetings bar one were virtual, with topics/speakers as follows in addition to core business:

Date	Topics / Speakers
20 March 2024	**Presentation on Scotland Excel information sharing, artificial intelligence, and cyber security issues. Shared training opportunities discussed and progressed.** • Danielle Pettigrew, Governance and Performance Manager, Scotland Excel
20 June 2024	**Presentation on the 2022/23 National Fraud Initiative, the forthcoming 2024/25 exercise, in particular data quality issues and how LA's could increase outcomes.** • Tim Bridle, Audit Scotland
18 September 2024	**Presentation and overview of the Investigatory Powers Act, and outline of the services, particular to the Act, that NAFN could provide.** • Paul Choudry, National Anti-Fraud Network (NAFN) **Case Study - Sharing lessons learned from a case study relating to the evasion of Council Tax with the provision of fictitious details.** • Bobbi Irvine, West Lothian Council
11 December 2024	**Presentation on the services available to local authorities from Transunion with regards credit reference data.** • Lydia Johnson and Greg Flewitt, Transunion **Case Study - Sharing lessons learned from a case study relating to a recent embezzlement case which resulted in a successful prosecution. Control weaknesses and red flags were discussed and good practice shared.** • Matthew Dickson, Aberdeen City Council

5.3 One specific task assigned to SLAIG was the Benchmarking on fraud activity and resources to align with the vison and objectives of SLACIAG and SLAIG's Terms of Reference. The proposal was agreed in March 2024 that all local authorities will participate in a benchmarking exercise. The core content of the exercise will include resources, training, and outcomes.

5.4 One of the SLACIAG Management Committee members is assigned as Senior Sponsor of SLAIG to provide direction re Group's meetings and agendas.

5.5 All Agendas, Minutes, and Presentations of SLAIG meetings, and other relevant documents are uploaded to the SLAIG Knowledge Hub to enable access by all members in a secure way.

6. CONCLUSION

6.1 Notwithstanding the challenges that continue to affect our organisations, SLACIAG and its Sub-Groups have had another successful year, as evidenced by the participation in our virtual meetings and the range of topics discussed.

6.2 During the year Chief Audit Executives considered significant matters facing our organisations such as Financial Sustainability Risks and Strategic Workforce Risks, engaged in the consultation of new Global Internal Audit Standards and assessed their impact on the provision of assurance and advisory services, and discussed other key issues and shared approaches being taken to address these. In line with their remits, the CASG and SLAIG Sub-Groups respectively focussed on computer audit and counter fraud matters that are affecting our organisations and our functions/individuals. The Data Analytics, Resourcing, Sustainability/Climate Change and Risk Sub-Groups are excelling in their exploration of specific matters. I give thanks to those who volunteer their time to achieve this.

6.3 I would like to thank the Management Committee and the Leads of our Sub-Groups for their work in organising meetings and responding to the challenges that have arisen. I would also like to thank our speakers for giving up their time to join us at our virtual meetings during 2024 and assist us in enhancing our effectiveness as providers of assurance and compliance services.

6.4 My thanks are also extended to our members for their support, as evidenced by engaging in our virtual meetings during 2024, but also by the generous advice and assistance provided in relation to the myriad of audit, risk and governance questions which have arisen within our membership during the year. SLACIAG relies on the dedicated and hard-working public sector professionals within its membership and look forward to our biennial 2-day in-person Conference on 5 and 6 June 2025.

Jill Stacey
Chief Officer Audit & Risk, Scottish Borders Council
Chair of SLACIAG

14 March 2025

ITEM No …7……..

REPORT TO: **SCRUTINY COMMITTEE - 25 APRIL 2025**

REPORT ON: **2025/26 INTERNAL AUDIT PLAN**

REPORT BY: **CHIEF INTERNAL AUDITOR**

REPORT NO: **128-2025**

1.0 PURPOSE OF REPORT

To submit to Members of the Scrutiny Committee the Internal Audit Plan for the 2025/26 financial year.

2.0 RECOMMENDATIONS

Members of the Committee are asked to review and approve the 2025/26 Internal Audit Plan as detailed at Appendix A.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

Introduction

4.1 Internal audit is defined in the Internal Audit Standards as:

"An independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes".

4.2 Management are responsible for establishing the risk, governance and internal control processes and systems as well as their on-going monitoring. Management are also responsible for managing fraud risks and ensuring that internal control systems are designed to guard against fraud and misappropriation. Internal audit is not a substitute for these management responsibilities. Rather it is the review function which will challenge current practices and recommend the best practice and improvements to lead to a strengthening of the control environment and therefore assist the council in achieving its objectives.

4.3 Professional practice in relation to the provision of internal audit service is defined by Global Internal Audit Standards (UK Public Sector) (GIAS (UK Public Sector)) which replaced the previous Public Sector Internal Audit Standards (PSIAS) from 1 April 2025. GIAS (UK Public Sector) is issued by the relevant authority which is CIPFA for local government. These standards are exacting in relation to the organisation's governance of internal audit and internal audit's own arrangements and practices.

4.4 GIAS (UK Public Sector) requires the Chief Internal Auditor to set a risk-based audit plan sufficient to provide the required assurances to Members and officers in relation to corporate governance, risk management and internal controls. Assurances are provided throughout the year as individual audits are completed. An annual conclusion on these areas is included within the Internal Audit Annual Report submitted to Scrutiny Committee in June each year.

4.5 An External Quality Assessment (EQA) reported in 2018 provided a positive conclusion confirming that Internal Audit fully conformed with nine of the 13 standards and generally conformed with the remaining four standards within the requirements of the PSIAS. An EQA is required every five years. The EQA underway currently was begun in November 2023. Completion has been delayed by the reviewer, but a draft report is expected in April 2025.

4.6 The Internal Audit plan is considered to be flexible to allow a quick response to any significant new requirement or change to Council risks. Any amendments to the plan will be brought to the Scrutiny Committee for approval.

4.7 The Internal Audit plan will be delivered in accordance with the Internal Audit Mandate and Charter to be approved in April 2025. This complies with the GIAS (UK Public Sector) which sets out the role, professional requirements, independence and overall responsibilities of Internal Audit. The authority, access rights and reporting arrangements for the Internal Audit function are also contained within the Internal Audit Mandate and Charter.

Resources

4.8 The Council's Internal Audit service is delivered by an in-house team which has been complemented by additional audit input from a contractor for a number of years. Azets were appointed to provide IT and general audit support for a four-year contract beginning with the 2023/24 audit year.

4.9 The in-house internal audit team structure has 4.3 FTE staff. The Chief Internal Auditor (CIA) (0.5 FTE), Acting Senior Manager – Internal Audit (0.8 FTE devoted to audit), Senior Auditor (1 FTE) and 2 auditors (2 FTE). The CIA post is currently filled through a secondment arrangement with Angus Council.

4.10 The Internal Audit team provides audit input to support the Chief Internal Auditor of the Dundee IJB (Integration Joint Board), who is from FTF Audit and Management Services. Discussions are in progress about providing a service to LACD.

4.11 For the 2025/26 financial year, the total productive days available for audit work will be of the order of 800 days. The time available for audits takes into account the work for the IJB noted above, the time needed for professional development of staff, internal administrative activities, annual leave and contingency for other staff absences, and involvement in corporate management groups.

4.12 Follow-up audit work will be undertaken with services as audit actions are closed in Pentana, with specific follow up reviews only considered for areas where the overall assurance level is limited or no assurance.

4.13 Where any team member has a perceived or actual conflict of interest in relation to an Internal Audit assignment or investigation, they will not be permitted to have any involvement in that piece of work. In addition, Internal Audit staff who are involved in advisory work will not be permitted to be involved in any internal audit work that is directly related to that work.

Assurance Framework and Mapping

4.14 Cipfa's December 2023 publication "Developing an effective assurance framework in a local authority" defines an assurance framework as

"The means by which leaders, managers and decision makers can have confidence that the governance arrangements that they have approved are being implemented, operating as intended, and remain fit for purpose."

4.15 The following diagram is an extract from the December publication and reflects the areas in the Council's Local Code of Corporate Governance (the Local Code).

4.16 An assurance map identifies in more detail the various ways in which management and those charged with Governance receive assurance about achievement of objectives and service delivery. It considers activity that provides assurance in four distinct areas: operational internal control: management oversight: external third-party oversight, and Internal Audit review.

4.17 In formulating the internal audit plan, review of the assurance map identifies:

- where sufficient alternative assurance to internal audit is in place, and therefore audit is not needed currently, and
- the internal processes that should be included in the audit universe so that audit can assess if they are providing control and assurance as intended.

4.18 A fully populated assurance map can identify gaps in assurance and areas where more assurance is gathered than is required, thereby releasing resources for other activity.

4.19 In developing the 2025/26 internal audit plan we used the Assurance Framework above to identify the key elements of the Council's assurance framework and map assurance sources to them. The Service self-assessment checklist that informs the Annual Governance Statement includes links to best practice and identifies Council policies, procedures and guidelines that make up the Framework and reports providing assurance information.

4.20 We ensured that key framework elements and internal assurance routes were included in our audit universe and that areas with external assurance sources were excluded from the plan to avoid duplication. Some of these external assurances may be taken into account in formulating the annual Chief Internal Auditor's opinion and time is set aside for reviewing reports and complying with GIAS (UK Public Sector) requirements about taking reliance from others.

4.21 Key assurance framework elements include:

- The Council Plan 2022 to 2027
- The City Plan for Dundee 2022 to 2032
- The Council's Vision, values and key priorities
- Service plans
- Over-arching thematic plans, e.g. medium-term financial plan.
- Codes of conduct for employees and members
- Statutory officers in place
- Strategies, policies and procedures
- Standing Orders and schemes of administration
- Committee arrangements, including Terms of Reference
- Transformation Programme and Programme Management Office
- Risk management arrangements
- Arrangements to comply with legislation, e.g. GDPR, Fairer Scotland
- Performance management framework
- Local Partnerships

4.22 The main reported assurance sources are:

- Annual performance reporting and self-evaluation by the Council and individual services.

- External Audit. This includes the annual audit report and opinion, Best Value reporting and other Audit Scotland publications.

- Inspection agency reports.

The 2025/26 Internal Audit Plan

4.23 A risk-based plan for the Council, outlining the planned programme of work to be undertaken by the Internal Audit Service, is developed annually in consultation with audit stakeholders. Appendix A presents the outcomes of the annual planning exercise and the Chief Internal Auditor's proposed 2025/26 Internal Audit Plan, for approval.

4.24 The planning process involves determining the potentially auditable areas of the Council and updating these each year. This year the high-level Audit Universe used previously was reviewed to record a more detailed audit universe. The auditable areas are identified from a number of sources including:

- Knowledge base within Internal Audit
- Council plans and policy documents
- Corporate risk register
- Service risk register
- External inspection reports
- Audit Scotland and Accounts Commission reports
- Liaison with external auditors
- Any matters arising from the work of the Scrutiny Committee
- Consultations with Scrutiny Committee members
- Consultations with the members of the Council Leadership Team and service managers

4.25 Each area in the audit universe is then risk assessed by:

- Mapping the risk registers, and the residual risk score to the audit universe,
- An independent assessment of risk by the Chief Internal Auditor, and
- Consideration of issues identified by audit stakeholders.

4.26 The final step in the development of the annual plan is to identify the individual audits from the audit universe. The selection is performed by categorising the audit universe according to the degree of assurance required in respect of those processes and process areas. Factors which contribute to a process or process area requiring a higher degree of assurance include where the process is assessed as:

- Being identified as high risk by stakeholders and/or Internal Audit's own assessment of risk;
- Being included as a mitigating action against high scoring risks in the Council's Risk Registers;
- Identified as essential or significant to the delivery of a Council objective;
- Not having been subject to previous review, or not reviewed in some time;
- An area of limited assurance in previous audits and inspections, or where counter fraud activity suggests control issues;
- Specifically requested by management and Elected Members;
- Audits carried forward from the previous year are also included.

4.27 The proposed portfolio of work to be included within the 2025/26 Internal Audit Plan is summarised at Appendix A. The layout of the plan as presented to Committee, in general, follows that used in previous years, with proposed reviews grouped into key themes that are integral to the assurance gathering process across the organisation's activities. For each of the reviews included within the plan there is a brief summary of the proposed coverage, currently informed by the Council's Corporate Risk Register, and service-level risk registers where appropriate. The proposed coverage has, in the main, been compiled based on discussions and review of relevant background information gathered as part of the audit planning process. A more detailed audit brief containing background information, scope of the work, overall/ specific objectives and reference sources will be compiled for each review and agreed with the client prior to commencement of the audit fieldwork.

Conclusion

4.28 The Chief Internal Auditor is content that the proposed plan in Appendix A has been prepared in accordance with GIAS (UK Public Sector) and will provide sufficient assurance to comply with the GIAS (UK Public Sector) requirements, including to inform the Chief Internal Auditor's annual conclusion on governance, risk management and internal controls.

4.29 Whilst the 2025/26 Internal Audit Plan has been prepared using the best information currently available, it is possible that it will require to be amended during the financial year to reflect changing risks, priorities and resources. As required under the GIAS (UK Public Sector), any significant changes to the planned programme of work will be reported to the Scrutiny Committee. The Chief Executive and Executive Director of Corporate Services will also be kept informed of Internal Audit developments by the Chief Internal Auditor through regular meetings.

5.0 POLICY IMPLICATIONS

This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6.0 CONSULTATIONS

The Council's Leadership Team have been consulted in the preparation of this report.

7.0 BACKGROUND PAPERS

None.

CATHIE WYLLIE, CHIEF INTERNAL AUDITOR **DATE: 2 April 2025**

2025/26 INTERNAL AUDIT PLAN	Proposed Coverage	Priority Theme	Corporate Risks	Service Risks
Finance Reviews				
Cash Handling	Review of the arrangements in place within the Council for the management and handling of cash.	Designing a Modern Council	DCC001 DCC013	CSCF008 CSCF010
Treasury Management (Large Value Transactions)	Review of procedures for processing and authorisation of large value transactions involving Council funds.	Designing a Modern Council	DCC001 DCC013	CSCF008 CSCF010
HRA Budgetary Control	Review of budget management and monitoring processes in relation to Housing Revenue Account funds.	Build Resilient and Empowered Communities	DCC004a DCC010	NSCo003 NSCo009
ICT Reviews				
ICT Reviews	Subject areas to be agreed with input from external support provider (Azets). Likely to be 2 specific reviews.			
Governance Reviews				
Performance Reporting	Assessment of organisational performance monitoring arrangements within Services, and their consistency with key operational plans.	All Council Plan Objectives	DCC004 DCC011	
Information Governance (progress of GDPR Action plan)	Review of Information Governance arrangements across the Council, including the progress of previous action plans.	All Council Plan Objectives	DCC007	
Dundee IJB – Implementation and Monitoring of Directions	Review of the governance and operational arrangements for the implementation and monitoring of Directions from Dundee IJB to the Council.	All Council Plan Objectives	DCC012	
Systems Reviews				
Asset Management	Review of the processes which ensure that the Council's asset management databases are complete, accurate, and kept up to date. To include processes for condition assessment.	Designing a Modern Council	DCC015c	
Employability Services	Review of the efficiency and effectiveness of the Employability pathway, and arrangements to implement the Scottish Government's *No one left behind* policy.	Inclusive Economic Growth	DCC004c	
Energy Management and Billing	Evaluation of the processes in place for energy metering and billing, including an assessment of value for money.	Designing a Modern Council	DCC001 DCC004b	

2025/26 INTERNAL AUDIT PLAN	Proposed Coverage	Priority Theme	Corporate Risks	Service Risks
Business Continuity Planning	Review of the extent to which Business Continuity Plans are in place, up to date, and consistent with Council policies and guidance, considering emergency planning and Service incident readiness plans.	All Council Plan Objectives	DCC003 DCC015	
Council Tax and Non-Domestic Rates refunds	Review of the processes and controls for managing Council Tax and Non-Domestic Rates refunds, taking cognisance of work already carried out within Digital and Customer Services on Council Tax Refunds.	Designing a Modern Council	DCC001 DCC013	CSCS007 CSCS008
DWP Appointeeships	Review of the arrangements in place within the Council for the management of DWP Appointeeship clients who are deemed incapable of managing their own affairs.	Designing a Modern Council	DCC009	CSCS007
Homelessness	Review of the development and progress of the Council's plans to address Homelessness.	Build Resilient and Empowered Communities	DCC004a	
Immigration Sponsorship and Visas	Review of the processes by which the Council considers and manages recruitment applications from individuals overseas and/or requiring visa sponsorship, including the update of these policies and procedures in line with changing legislation.	Designing a Modern Council	DCC008 DCC009	CSPS001 CSPS005
Payroll	Review of a payroll sub-process, to be selected in conjunction with Service management.	Designing a Modern Council	DCC001 DCC008	CSPS001 CSPS004
Schools Administrative Support	Review of the arrangements to provide administrative and office support to schools, including arrangements for backfill in the event of absence.	Reduce child poverty and inequalities in incomes, education & health		CFED012
Self-Directed Support	Review of the arrangements for the uptake of and management of self-directed support within Children Services.	Reduce child poverty and inequalities in incomes, education & health	DCC009	CFCJ004 CFCJ006
Other Work				
Parking Meter Procurement	Review of the procurement process for the tender with Project Number DCC/CD/111/24, to confirm that the procurement process used is	Designing a Modern Council	DCC009	CSCF008 CSCF010

2025/26 INTERNAL AUDIT PLAN	Proposed Coverage	Priority Theme	Corporate Risks	Service Risks
	consistent with Council procurement procedures and the requirements of the tender specification.			
Purchasing outwith Civica - Tranman	Review processes which are specific to the Fleet function for placing and approving orders, receipting, and approval of payments.	Designing a Modern Council	DCC009	CSCF008 CSCF010
Purchasing outwith Civica - GVA	Review processes in relation to the ordering, approval, and payment for repair work to Council buildings which are administered through the GVA system and related processes.	Designing a Modern Council	DCC009 DCC015	CSCF008 CSCF010
Follow-Up	Review of progress with the implementation of prior internal audit actions agreed by the Council, for the purpose of providing assurance to Elected Members that identified issues are addressed on a timely basis, and that management attention is appropriately directed towards issues which expose the Council to higher degrees of risk.			
Prior Year Work	Finalisation of projects that are currently ongoing or nearing completion at June 2025.			
Technical Development	Review and update of the Council's Internal Audit Methodology following the implementation of Global Internal Audit Standards. Further refinement of the Council Audit Universe in consultation with Services. Development and implementation of a Data Analytics strategy and capability.			
Advice and Guidance	Provision of ad-hoc support to assist services in respect of specific queries and contribute to the delivery of improvements in the Council's framework of governance, risk management and control. This will include the ongoing provision of advice and guidance surrounding the development of newly implemented systems and processes, or the revision and update of those processes.			
GIAS (UK Public Sector) Quality Self-Assessment Process	Annual self-assessment for conformance with GIAS (UK Public Sector).			CSCF008

2025/26 INTERNAL AUDIT PLAN	Proposed Coverage	Priority Theme	Corporate Risks	Service Risks
Specific Investigations	To respond to requests for advice and assistance as required in respect of cases of suspected fraud, corruption or malpractice.		DCC013	

Reserve List

Community Wealth Building	Review of the progress and implementation of a Community Wealth Building Strategy and Action Plan.	Deliver Inclusive Economic Growth	DCC004c	
Events Management	Review of the Council's arrangements for hosting and managing events in the City.	Inclusive Economic Growth	DCC004c	
Trade Waste	Review of the processes and controls in respect of managing the arrangements for trade waste.	Tackle Climate Change and Reach Net Zero Carbon Emissions		NSEN007 NSEN008
Onboarding & Induction	Review of onboarding processes for all staff, and the guidance available to line management overseeing and recording the onboarding of new starts. (Carried forward from 2024/25 plan).	Designing a Modern Council	DCC008	CSPS001
External Grant Funding	Review of the arrangements for the receipt of External Grant Funding and the governance over the requirements and conditions under which the Funding is received.	May impact any Priority Theme	DCC004c	

ITEM No …8……..

REPORT TO: **SCRUTINY COMMITTEE - 23 APRIL 2025**

REPORT ON: **INTERNAL AUDIT STRATEGY, AND MANDATE AND CHARTER**

REPORT BY: **CHIEF INTERNAL AUDITOR**

REPORT NO: **129-2025**

1.0 PURPOSE OF REPORT

To submit to Members of the Scrutiny Committee the Internal Audit Mandate and Charter and the Internal Audit Strategy required by new Global Internal Audit Standards (UK Public Sector) (GIAS (UK Public Sector)).

2.0 RECOMMENDATIONS

It is recommended that the Committee:-

(i) Consider and approve the Internal Audit Mandate and Charter (Appendix 1) including any required updates; and

(ii) Note that the Strategy (Appendix 2) is designed to aid Internal Audit in achieving the agreed Mandate and confirm this position or make suggestions for amendments.

3.0 FINANCIAL IMPLICATIONS

None - provision for Internal Audit is already included in the Council's budget.

4.0 REQUIREMENT FOR INTERNAL AUDIT STRATEGY, MANDATE AND CHARTER

4.1 Local Authorities in Scotland are required by regulation to have an Internal Audit service and to conform with recognised standards and practices in relation to internal auditing. The recognised standards have been revised and the previously applicable Public Sector Internal Audit Standards (PSIAS) were replaced by GIAS (UK Public Sector) from 1 April 2025.

4.2 For Local Government GIAS (UK Public Sector) comprises:

- The Global Internal Audit Standards (GIAS) – issued in January 2024, https://www.theiia.org/en/standards/2024-standards/global-internal-audit-standards/
- The Application Note; Global Internal Audit Standards in the UK Public Sector – issued December 2024 https://www.cipfa.org/policy-and-guidance/standards/global-internal-audit-standards-in-the-uk-public-sector and
- Cipfa's Code of Practice on the Governance of Internal Audit (the Cipfa Code) Issued February 2025 CIPFA Code of Practice for the Governance of Internal Audit in UK Local Government

4.3 GIAS (UK Public Sector) requires that the Chief Audit Executive prepare an Internal Audit Strategy with input from senior managers and the audit committee. It also requires input from senior management and the audit committee for the Internal Audit Mandate and Charter, which should be approved by the Scrutiny Committee. Drafts of the documents were discussed with CLT for their input on 11 March 2025. Briefing sessions for all Elected members were arranged for 14 and 15 April 2025.

4.4 The Mandate and Charter require consideration and approval by the Scrutiny Committee. The Strategy requires consideration and comment from the Scrutiny Committee, including that the committee be satisfied the strategy supports achievement of the Mandate.

5.0 POLICY IMPLICATIONS

This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services, or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6.0 CONSULTATIONS

The Council Leadership Team have been consulted in the preparation of this report.

7.0 BACKGROUND PAPERS

The following background papers, as detailed by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information) were relied on to a material extent in preparing the above report.

The Local Authority Accounts (Scotland) Regulations 2014;
The Global Internal Audit Standards - issued in January 2024;
The Application Note; Global Internal Audit Standards in the UK Public Sector - issued December 2024; and
Cipfa's Code of Practice on the Governance of Internal Audit Issued February 2025

Appendix 1 – Draft Internal Audit Mandate and Charter

Appendix 2 – Draft Internal Audit Strategy

CATHIE WYLLIE, CHIEF INTERNAL AUDITOR **27 March 2025**

INTERNAL AUDIT

MANDATE AND CHARTER

Contents

Mandate and Charter

This document comprises the Mandate and Charter, as defined below by the Global Internal Audit Standards (UK Public Sector), for Dundee City Council's Internal Audit Service. It will be reviewed annually and presented to the Scrutiny Committee for final approval.

For Local Government GIAS (UK Public Sector) comprises:-

The Global Internal Audit Standards (GIAS) - issued in January 2024 https://www.theiia.org/en/standards/2024-standards/global-internal-audit-standards/
The Application Note; Global Internal Audit Standards in the UK Public Sector - issued December 2024 https://www.cipfa.org/policy-and-guidance/standards/global-internal-audit-standards-in-the-uk-public-sector and
Cipfa's Code of Practice on the Governance of Internal Audit (the Cipfa Governance Code), issued February 2025 CIPFA Code of Practice for the Governance of Internal Audit in UK Local Government

The GIAS (UKPS) has the following five Domains. Each Domain includes Principles, under which the individual Standards sit.

Domain I: Purpose of Internal Auditing
Domain II: Ethics and Professionalism
Domain III: Governing the Internal Audit Function
Domain IV: Managing the Internal Audit Function
Domain V: Performing Internal Audit Services

Definitions

The Council has adopted the following definitions from GIAS:-

Internal audit function - A professional individual or group responsible for providing an organisation with assurance and advisory services.

Assurance Services - Services through which internal auditors perform objective assessments to provide assurance. Examples of assurance services include compliance, financial, operational/performance, and technology engagements. Internal auditors may provide limited or reasonable assurance, depending on the nature, timing, and extent of procedures performed.

Advisory Services - Services through which internal auditors provide advice to an organisation's stakeholders without providing assurance or taking on management responsibilities. The nature and scope of advisory services are subject to agreement with relevant stakeholders. Examples include advising on the design and implementation of new policies, processes, systems, and products; providing forensic services; providing training; and facilitating discussions about risks and controls. "Advisory services" are also known as "consulting services."

Internal auditing - An independent, objective assurance and advisory service designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of governance, risk management, and control processes.

Independence - The freedom from conditions that may impair the ability of the internal audit function to carry out internal audit responsibilities in an unbiased manner.

Internal audit mandate - The internal audit function's authority, role, and responsibilities, which may be granted by the board and/or laws and regulations.

Internal audit charter - A formal document that includes the internal audit function's mandate, organisational position, reporting relationships, scope of work, types of services, and other specifications.

In addition, key roles defined in GIAS are filled as follows in Dundee City Council:-

Chief Audit Executive (CAE) - Chief Internal Auditor

Board - Scrutiny Committee (the Committee)

Senior management - Corporate Leadership Team

Purpose of Internal Auditing

GIAS defines the Purpose of Internal Auditing in Domain I as follows:-

"Internal auditing strengthens the organisation's ability to create, protect, and sustain value by providing the board and management with independent, risk-based, and objective assurance, advice, insight, and foresight.

Internal auditing enhances the organisation's:-

- Successful achievement of its objectives.
- Governance, risk management, and control processes.
- Decision-making and oversight.
- Reputation and credibility with its stakeholders.
- Ability to serve the public interest.

Internal auditing is most effective when:-

- It is performed by competent professionals in conformance with the Global Internal Audit Standards, which are set in the public interest.

- The internal audit function is independently positioned with direct accountability to the board.

- Internal auditors are free from undue influence and committed to making objective assessments."

Authority

Internal Audit's authority derives from The Local Authority Accounts (Scotland) Regulations 2014 (The Regulations).

The Regulations require all Scottish Local Authorities to operate a professional and objective internal auditing service, which must be delivered in accordance with recognised standards. The standards and practices applied in the UK for all public sector internal audit providers, in-house, shared, or outsourced, are Global Internal

Audit Standards in the UK Public Sector (GIAS (UK Public Sector)). These apply from 1 April 2025 and replace the previously applicable Public Sector Internal Audit Standards (PSIAS).

The Regulations also:-

- outline internal auditors' rights to access the organisation's accounting and other records, and to receive information and explanations necessary for the purposes of internal auditing, and

- require a local authority from time to time to assess the efficiency and effectiveness of its internal auditing, in accordance with the relevant standards and practices and to use the findings as part of its consideration of the systems of internal control.

The nature of the assurance services provided by Internal Audit include, but are not limited to the following:-

- Risk based audit
- Developing systems audit
- Compliance audits
- Value for money/best value audits
- Quality assurance audits
- Advisory reviews

The scope of Internal Audit allows for unrestricted coverage of the Council's activities. In addition, Internal Audit through the Chief Internal Auditor, where they deem necessary, will have unrestricted access to:-

- The Chief Executive
- The Scrutiny Committee and all members
- Members of the extended Council leadership team
- All Council employees

All internal audit staff shall have authority to:-

- enter any Council premises or land.

- have full, free, and unrestricted access to, and remove, all records, documents, and correspondence which, in the view of the Chief Internal Auditor (or nominated representatives), are considered to relate to any matter which may have audit or assurance implications for the Council.

- be provided with full access to any computer system and personal computer or other computer storage device/media in the ownership of the Council.

- require explanations considered necessary from any employee, including members of the extended Council leadership team.

- require any employee, or agent of the Council, to produce cash, stores, assets, or any other property under his control or to which he has access.

Internal audit will safeguard all information obtained in performing its work and will only use it for the purposes of an audit, investigation or advisory work. Internal audit will not disclose any information held unless this is authorised or there is a legal or professional requirement to do so.

Internal audit resources will be managed and monitored withing the Council's overall budget setting and monitoring arrangements. Changes in circumstances that impair resources to an extent that may compromise the achievement of the Mandate will be reported to CLT and the Committee.

All employees and members are requested to assist Internal Audit in fulfilling its roles and responsibilities.

Role and Responsibilities

The Chief Internal Auditor will develop and implement a strategy for the internal audit function which will be reviewed periodically with the Committee and senior management.

As part of the Council's governance and assurance framework the main objective of Internal Audit is to provide, in terms of the GIAS (UK Public Sector), a high quality, independent audit service to the Council which:-

- Supports the delivery of the authority's strategic objectives by providing risk-based and objective assurance on the adequacy and effectiveness of governance, risk management and internal controls.

- Champions good practice in governance through assurance, advice and contributing to the authority's annual governance review.

- Advises on governance, risk management and internal control arrangements for major projects, programmes, and system changes.

Right of access to other bodies funded by the Council should be set out in the conditions of funding to ensure Internal Audit has aaccess to the authority's collaborative and arm's-length arrangements.

Internal Audit will also:-

- Support the Executive Director of Corporate Finance in discharge of their Section 95 Officer duties.

- Support the Head of Democratic and Legal Services in discharge of their Monitoring Officer duties.

- Provide advisory services to directorates.

- Advise on internal control implications of new systems and provide a project assurance service.

- Support the Council and Senior Management during key transformational/ change projects.

The standards defined in this document will also apply to any work which may be carried out to provide assurance services to parties external to the Council.

The existence of internal audit does not diminish the responsibility of management to ensure that resources are properly applied in a manner and on the activities intended and the internal control arrangements are sufficient to address the risks facing their services.

Periodic Assessment

Internal Audit is subject to a Quality Assurance and Improvement Programme that covers all aspects of internal audit activity. This consists of an annual self-assessment of the service and its compliance with the GIAS (UK Public Sector), ongoing performance monitoring and external assessment.

Self-assessment results will be reported to Senior Management and the Committee in the Chief Internal Auditor's Annual Report to the Committee.

External assessments will be conducted at least every five years in accordance with GIAS (UK Public Sector). Review arrangements and findings will be reported to the Committee. The scope of the review will be agreed with the Convener of the Committee.

The Chief Internal Auditor is responsible for providing periodic self-assessment on the internal audit activity as regards its performance against its objectives, ability to fulfil the Audit Mandate and performance relative to the Annual Plan. This will be reported in progress reports to Committee throughout the year and in the Chief Internal Auditor's Annual Report.

Ethics and Professionalism

Internal audit will conform with the GIAS (UK Public Sector).

This mandatory guidance constitutes principles of the fundamental requirements for the professional practice of internal auditing and for evaluating the effectiveness of the internal audit activity's performance.

Other professional guidance will also be adhered to as applicable to guide operations. In addition, Internal Audit will adhere to the Council's relevant policies and procedures and Internal Audit's standard operating procedures manual.

A programme of Continuous Professional Development (CPD) is maintained for all staff working on audit engagements to ensure that auditors maintain and enhance their knowledge, skills, and audit competencies.

Internal auditors will:-

- conform with the GIAS (UK Public Sector) principles of Ethics and Professionalism: integrity, objectivity, competency, due professional care, confidentiality, and the Nine Key Principles of Public Life in Scotland.

- understand, respect, meet, and contribute to the legitimate and ethical expectations of the Council and be able to recognise conduct that is contrary to those expectations.

- encourage and promote an ethics-based culture in the Council.

- report organisational behaviour that is inconsistent with the Council's ethical expectations, as described in applicable policies and procedures.

Organisational Position and Reporting Relationships

The Chief Internal Auditor is the senior officer responsible to the Committee for the provision of a full independent core assurance internal audit service. The Chief Internal Auditor is seconded from Angus Council and will discharge their responsibility through a directly employed team. Specialist support for computer audit, and general audit if required, will be procured via an external tendering exercise.

The Chief Internal Auditor will be the Chief Audit Executive for the purposes of the GIAS (UK Public Sector). In relation to this the Chief Internal Auditor will report functionally to the Committee, and administratively to the Head of Finance. In this context functional reporting means the Committee will:-

- Approve the audit mandate and charter.

- Approve the Internal Audit risk based internal audit plan, ensuring there are no inappropriate limitations on scope.

- Receive reports from the Chief Internal Auditor on the result of Internal Audit activity or other matters the Chief Internal Auditor determines necessary, including an annual conclusion regarding governance, risk management and control.

It is recognised the administrative reporting line does not have authority over the scope or reporting of results of Internal Audit activity. Ultimate authority in this regard vests in the Chief Internal Auditor, who reports in their own name and retains final right of edit over all Internal Audit reports.

The Chief Internal Auditor will also have open access to the Chief Executive and Corporate Leadership Team. The Chief Internal Auditor will be responsible to the Committee for all elements of core assurance internal audit planning, delivery and reporting and provision of an annual report and conclusion on governance, risk management and internal control.

The Chief Internal Auditor, and the Acting Senior Manager - Internal Audit are required to hold a professional qualification and be suitably experienced.

Independence and Objectivity

To maintain the internal auditors' independence and objectivity, Internal Audit activity will remain free from interference by any element in the organisation, including matters of engagement selection, scope, procedures, frequency, timing, and communication.

Internal auditors will have no direct operational responsibility or authority over any of the activities audited. Accordingly, they will not implement internal controls, develop procedures, install systems, manage risks, prepare records, or engage in any other activity that may impair internal auditor's judgment.

The Acting Senior Manager - Internal Audit has line management responsibility for risk management and insurance. These services will be audited when required by the external contractor.

Internal auditors must exhibit the highest level of professional objectivity in gathering, evaluating, and communicating information about the activity or process being examined. Internal auditors must make a balanced assessment of all the relevant circumstances and not be unduly influenced by their own interests or by others in forming judgments.

The Chief Internal Auditor will confirm to the Committee, at least annually, the organisational independence of the internal audit activity. Any interference experienced will be disclosed by the Chief Internal Auditor to the Committee and the implications discussed.

Scope of work

The scope of internal auditing covers the entire breadth of the Council, and encompasses, but is not limited to, the examination and evaluation of the adequacy and effectiveness of the Council's governance, risk management, and internal control processes in relation to the Council's defined goals and objectives.

Internal Audit is responsible for evaluating all processes ('audit universe') of the entity including governance processes and risk management processes. In doing so, Internal Audit maintains a proper degree of co-ordination with external audit and other assurance providers as appropriate.

Based on its activity, Internal Audit is responsible for reporting significant risk exposures and control issues identified to the Committee and to Senior Management (the Council's Corporate Leadership Team), including fraud risks, governance issues, and other matters needed or requested by the committee.

Internal Audit resources may be used to support advisory services, related to governance, risk management and control, but not to the detriment of provision of core assurances. It may also evaluate specific operations at the request of the Committee or senior management, as appropriate.

Fraud and Corruption

Managing the risk of fraud and corruption is the responsibility of management. Management is also responsible for developing, implementing, and maintaining systems of internal control to guard against fraud or irregularity and ensure probity in systems and operations. Internal Audit will assist management by reviewing the controls and procedures in place.

Audit procedures alone cannot guarantee that fraud and corruption will be detected, nor does Internal Audit have the responsibility for prevention and detection of fraud. However, when planning and undertaking assignments individual auditors will be alerted to risks and exposures that could allow fraud, irregularity, or corrupt practice to take place.

Financial Regulations lay out the responsibilities of Council Officers, Managers and other staff in relation to any suspicion of fraud or irregularity. The Counter Fraud Team

will fully investigate any suspicion of fraud, irregularity or corrupt practice and report in accordance with the Fraud Response Plan.

Internal Audit Plan

At least annually, the Chief Internal Auditor will submit an internal audit plan that includes risk assessment criteria to the Committee for review and approval. The Chief Internal Auditor will communicate the impact of any resource limitations and significant interim changes to senior management and the Committee.

The internal audit plan will be developed based on a prioritisation of the audit universe using a risk-based methodology and will take into account the requirement placed upon the Chief Internal Auditor to deliver an annual internal audit conclusion on the overall adequacy and effectiveness of the organisation's governance, risk management and control framework. In compiling the plan input from senior management and the Committee and any other relevant parties will be sought. Prior to submission to the Committee for approval the plan will be submitted to the Council Leadership Team for comment. Any significant deviation from the approved internal audit plan will be communicated through the periodic activity reporting process to the Committee.

Audits will only be allocated to staff who have the appropriate skills, experience, and competence.

Reporting and Monitoring

A written report will be prepared and issued by the Chief Internal Auditor or Acting Senior Audit Manager - Internal Audit following the conclusion of each Internal Audit engagement and will be distributed as appropriate for management responses and comment. Internal Audit results will also be reported to the Committee.

The Internal Audit report may include management's response and corrective action taken, or to be taken, in regard to the specific findings and recommendations. Management's response should include an action owner, a timetable for anticipated completion of action to be taken and an explanation for any corrective action that will not be implemented. Agreed actions will be monitored using the Council's Performance Management system. Action owners should update the Council's Performance Management System with progress of implementation.

Internal Audit will be responsible for appropriate follow-up on engagement findings and recommendations. All significant findings will remain open until evidentially cleared.

Approved by the Scrutiny Committee on 23 April 2025

Dundee City Council Internal Audit Strategy April 2025 to June 2028

(Draft 24 March 2025)

Mission Statement (Purpose) To protect public resources.

Vision Statement (Ambition) To provide assurance on internal controls, governance and risk management through internal audit and advisory services.

Values

Our customers and what we offer them

Service departments and directorates of the Council, and related organisations (e.g. Trusts, Joint Boards, IJB), the extended Council Leadership Team, Chief Executive, and elected/Board members.

We offer assurance, advice and insight related to internal controls, governance arrangements and risk management. We will consider good practice and be pragmatic in considering how best that can be applied effectively and efficiently in various circumstances, providing clear commentary on risk exposure.

An annual conclusion will be provided on internal controls, governance, and risk management.

Key partners

The organisation's management team; audit sponsors; and key contacts in every audit. There is formal engagement to prepare the internal audit plan, to agree the scope and timing of each individual audit, undertake the audit, and agree any required actions and a final report. Informal communication is ongoing through audit team membership of various groups and individual contact.

SLACIAG (Scottish Local Authorities Chief Internal Auditor Group) and professional networks. We work with other local authority and public sector internal audit services to share knowledge and information and engage at national level with relevant organisations, e.g. Cipfa.

The specialist IT audit support contractor. Work with this partner enhances the service provided and contributes to the annual conclusion and levels of assurance provided.

Audit Scotland/external auditor. Work with these partners ensues maximum audit assurance is provided, and overlap is minimised.

The IJB internal auditor. We provide input to the IJB auditor's plan to ensure sufficient audit coverage and fulfil partnership agreements for resource provision.

Council Counter Fraud Team. Sharing information between teams enhances the work of both teams.

Core competency

Internal audit competency as noted in Global Internal Audit Standards (UK Public Sector) (GIAS (UKPS)) requires all auditors to have the knowledge, skills, and abilities suitable for their job position. This includes competency in specialist areas such as IT, contract management, cyber security, and procurement. This is achieved through professional qualifications, continuous professional development, targeted training for individuals, and supervisory feedback.

Resources

People: Agreed career grade structure for in house team led by CAE supplemented by an external contractor to provide IT specialist knowledge and additional general audit input if required. This structure, including a mix of suitably qualified professional and trainee posts, is sufficient to deliver the service in compliance with GIAS (UKPS). Recruitment and development of people managed through our Workforce Plan and appraisal arrangements will ensure we maintain core competencies within the team to satisfy GIAS (UKPS) requirements. Job sharing has been agreed between Dundee City Council and Angus Council re CAE post.

Systems: Council IT network, Microsoft office (primarily word, excel, office 365) Use of Power BI to be explored.

Financial: Salary budget tied to approved posts and career grade structure. Budget agreed annually and monitored monthly. Some costs, e.g. training, bid for through organisation's central arrangements. Time supplied to related organisations (Leisure Trust; IJB) through service level agreements of the Council is not re-charged.

Risk

- We do not maintain team numbers and skills at the level required to deliver the service
- We do not deliver work to the level required by the GIAS (UKPS)
- Poor engagement from auditees compromises efficient and effective delivery of the audit, its findings, and improvements to address control weaknesses and risks.

Strategic Objectives and Priorities

Our Strategic objective is to provide, in terms of the GIAS (UKPS), a high quality, independent audit service to the Council which:

- Supports the delivery of the authority's strategic objectives by providing risk-based and objective assurance on the adequacy and effectiveness of governance, risk management and internal controls.

- Champions good practice in governance through assurance, advice and contributing to the authority's annual governance review.

- Advises on governance, risk management and internal control arrangements for major projects, programmes, and system changes.

Strategic Priority	Impact/Outcome	Measure
Short-term - By June 2026		
Implement revised GIAS (UKPS), applicable from 1 April 2025	Review/update procedures and documents, including Strategy, Mandate, Charter, Annual Plan and Annual Conclusion Maintain regulatory/statutory compliance	Significant level of compliance (at least general compliance) with GIAS (UKPS) assessed in annual self-assessments and external Quality Assessments every 5 years
Continue close internal audit collaboration between Dundee City Council and Angus Council	Sharing of information Joint development of procedures	Joint working activity
Review of strategic arrangement for sharing CAE post between Angus and Dundee ahead of end of current agreement in December 2026	Reduce uncertainty for team members Maintain continuity of service delivery Compliance with GIAS (UKPS) requirements re CAE	Plan in place prior to end of current arrangement Smooth transition to new arrangement
Medium-term - Over next 2 to 3 years		
Develop digital audit activity - initial exploration re use of Power BI	Provision of relevant, useful, real-time/continuous audit assurances	Number of areas where digital/continuous audit is applied and reported regularly to management and audit committee
Explore use of AI (Artificial Intelligence)	To improve efficiency and effectiveness of audit work	Options appraisal of potential AI use and implementation where deemed to provide an improvement to current processes
Implement workforce plan to maintain and increase knowledge and skills available to deliver the required services, including specialist areas identified in GIAS (UKPS)	Well informed team members who can audit/investigate areas of significant risk. Identification of specialist areas where cost/benefit indicates external support is most effective option	All team members achieve Continuous Professional Development (CPD) requirements. Exam pass and career grade progression where applicable Support contract work integrated with annual internal audit plan where required
Performance of joint audits where practical and if Council systems become more aligned or shared	Efficiencies in audit time spent	Number of joint audits performed compared to the number of aligned and shared services assessed as high-risk areas

ITEM No …9……

REPORT TO: **SCRUTINY COMMITTEE - 23 APRIL 2025**

REPORT ON: **DUNDEE CITY COUNCIL - AUDIT SCOTLAND ANNUAL AUDIT PLAN 2024/25**

REPORT BY: **EXECUTIVE DIRECTOR OF CORPORATE SERVICES**

REPORT NO: **134-2025**

1 PURPOSE OF REPORT

To submit to elected members the above report that describes how Audit Scotland will deliver the audit of Dundee City Council for the year ending 31 March 2025.

2 RECOMMENDATIONS

It is recommended that elected members:

(i) note the information included in the attached report;

(ii) note that the outcome of the 2024/25 audit will be reported to the Scrutiny Committee on 24 September 2025.

3 FINANCIAL IMPLICATIONS

The agreed external audit fee for 2024/25 is £456,600 which is an increase of £17,293 (3.9%) from 2023/24. Provision for the external audit fee has been made in the Corporate Services revenue budget. There is also an additional audit fee of £8,100 for the audit of the Council's registered charities, an increase of £600. There are no further direct financial implications arising from this report.

4 MAIN TEXT

4.1 Audit Scotland has been appointed as external auditor for Dundee City Council for five years from 2022/23 to 2026/27 inclusive. They have produced the above report outlining the planned approach to the audit of Dundee City Council for the year ending 31 March 2025. The document sets out the statutory and professional responsibilities in terms of the Code of Audit Practice and also outlines their key audit objectives.

4.2 The report is divided into the following sections:

- Introduction (page 3)
- Audit scope and responsibilities (pages 4-13)
- Wider Scope and Best Value (pages 14-15)
- Reporting Arrangements, Timetable and Audit Fee (pages 16-18)
- Other Matters (page 19)

4.3 In paragraph 36 on page 14 of the report, the external auditor advises that the audit of Best Value is fully integrated within their annual audit work. In addition, thematic reviews will be conducted as directed by the Accounts Commission.

4.4 Exhibit 2 on pages 8 to 9 of the report sets out the risks of material misstatement and audit procedures that Audit Scotland plan to perform to gain assurances over these risks. The conclusions from this work will be report within the 2024/25 Annual Audit Report.

5 POLICY IMPLICATIONS

This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6 CONSULTATIONS

The Council Leadership Team were consulted in the preparation of this report and agreed with its contents.

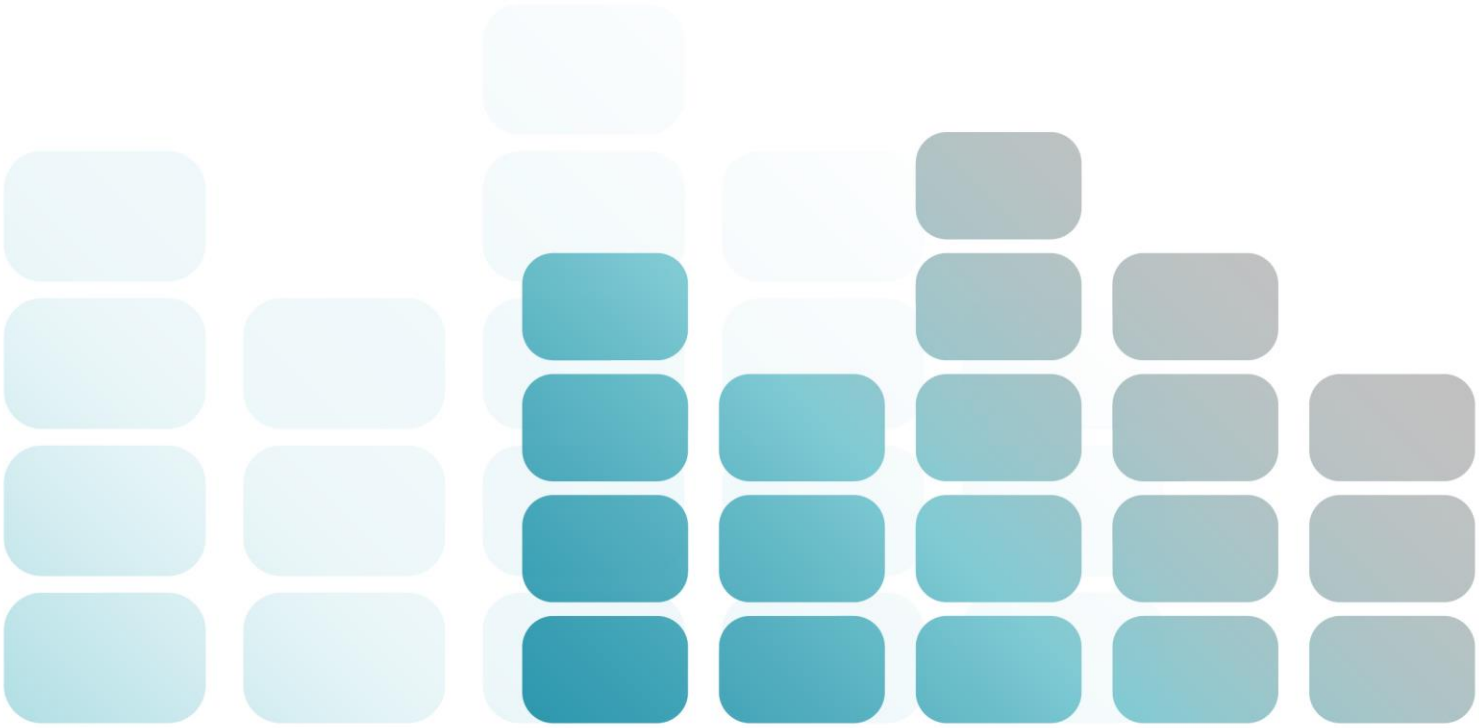
7 BACKGROUND PAPERS

None.

PAUL THOMSON **1 APRIL 2025**
EXECUTIVE DIRECTOR OF CORPORATE SERVICES

Dundee City Council

Annual Audit Plan 2024/25



AUDIT SCOTLAND

Prepared for Dundee City Council
March 2025

Contents

Accessibility

You can find out more and read this report using assistive technology on our website www.audit.scot/accessibility.

Introduction

Purpose of the Annual Audit Plan

1. The purpose of this Annual Audit Plan is to provide an overview of the planned scope and timing of the 2024/25 audit of Dundee City Council's (the council) annual accounts. It outlines the audit work planned to meet the audit requirements set out in auditing standards and the Code of Audit Practice, including supplementary guidance.

Appointed auditor and independence

2. Rachel Browne, of Audit Scotland, has been appointed by the Accounts Commission as external auditor of the council for the period from 2022/23 until 2026/27. The 2024/25 financial year is therefore the third of the five-year audit appointment.

3. Rachel Browne and the audit team are independent of the council in accordance with relevant ethical requirements, including the Financial Reporting Council's Ethical Standard. This standard imposes stringent rules to ensure the independence and objectivity of auditors. Audit Scotland has robust arrangements in place to ensure compliance with ethical standards. The arrangements are overseen by the Executive Director of Innovation and Quality, who serves as Audit Scotland's Ethics Partner.

4. The Ethical Standard requires auditors to communicate any relationships that may affect the independence and objectivity of the audit team. There are no such relationships pertaining to the audit of the council to communicate.

Audit scope and responsibilities

Scope of the audit

5. The audit is performed in accordance with the Code of Audit Practice, including supplementary guidance, International Standards on Auditing (UK), and relevant legislation. These set out the requirements for the scope of the audit which includes:

- An audit of the financial statements and an opinion on whether they give a true and fair view and are free from material misstatement.
- An opinion on statutory other information published with the financial statements in the annual accounts, the Management Commentary, and the Annual Governance Statement, and an opinion on the audited part of the Remuneration Report.
- Conclusions on the council's arrangements in relation to the wider scope areas: Financial Management, Financial Sustainability, Vision, Leadership, and Governance, and Use of Resources to Improve Outcomes.
- Reporting on the council's arrangements for securing Best Value.
- Providing assurance on the Housing Benefit Subsidy Claim, Non-Domestic Rates Return and the Whole of Government Accounts return.
- A review of the council's arrangements for preparing and publishing statutory performance information.
- Provision of an Annual Audit Report setting out significant matters identified from the audit of the annual accounts and the wider scope areas specified in the Code of Audit Practice.

Responsibilities

6. The Code of Audit Practice sets out the respective responsibilities of the council and the auditor. A summary of the key responsibilities is outlined below.

Auditor's responsibilities

7. The responsibilities of auditors in the public sector are established in the Local Government (Scotland) Act 1973. These include providing an independent opinion on the financial statements and other information

reported within the annual accounts, and concluding on the council's arrangements in place for the wider scope areas.

The council's responsibilities

8. The council has primary responsibility for ensuring proper financial stewardship of public funds, compliance with relevant legislation and establishing effective arrangements for governance, propriety and regularity that enables it to successfully deliver its objectives. The features of proper financial stewardship include:

- Establishing arrangements to ensure the proper conduct of its affairs.
- Preparation of annual accounts, comprising financial statements and other information that gives a true and fair view.
- Establishing arrangements for the prevention and detection of fraud, error and irregularities, and bribery and corruption.
- Implementing arrangements to ensure its financial position is soundly based.
- Making arrangements to secure Best Value.
- Establishing an internal audit function.

Communication of fraud or suspected fraud

9. In line with the ISA (UK) 240 *(The Auditor's Responsibilities Relating to Fraud in an Audit of Financial Statements)*, in presenting this plan to the Scrutiny Committee we seek confirmation from those charged with governance of any instances of actual, suspected or alleged fraud that should be brought to our attention. Should members of the committee have any such knowledge or concerns relating to the risk of fraud within Dundee City Council, we invite them to communicate this to the appointed auditor for consideration. Similar assurances will be sought as part of the audit completion process.

Audit of the annual accounts

10. The audit of the annual accounts is driven by materiality and the risks of material misstatement in the financial statements, with greater attention being given to the significant risks of material misstatement. This chapter outlines materiality, the significant risks of material misstatement that have been identified, and the impact these have on the planned audit procedures.

Materiality

11. The concept of materiality is applied by auditors in planning and performing an audit, and in evaluating the effect of any uncorrected misstatements on the financial statements or other information reported in the annual accounts.

12. Broadly, the concept of materiality is to determine whether matters identified during the audit could reasonably be expected to influence the decisions of users of the financial statements. Auditors set a monetary threshold when determining materiality, although some issues may be considered material by their nature. Therefore, materiality is ultimately a matter of the auditor's professional judgement.

13. The materiality levels determined for the audit of Dundee City Council and its group are outlined in Exhibit 1.

Exhibit 1
2024/25 Materiality levels for Dundee City Council and its group

Materiality	Council only	Group
Materiality – based on an assessment of the needs of users of the financial statements and the nature of the council's operations, the benchmark used to determine materiality is gross expenditure based on the audited 2023/24 financial statements. Materiality has been set at 2 per cent of the benchmark.	£16.8 million	£17.5 million
Performance materiality – this acts as a trigger point. If the aggregate of misstatements identified during the audit exceeds performance materiality, this could indicate that further audit procedures are required. Using professional judgement, performance materiality has been set at 50 per cent of planning materiality.	£8.4 million	£8.75 million

Materiality	Council only	Group
Reporting threshold – all misstatements greater than the reporting threshold will be reported.	£0.5 million	£0.5 million

Source: Audit Scotland

Significant risks of material misstatement to the financial statements

14. The risk assessment process draws on the audit team's cumulative knowledge of the council, including the nature of its operations and its significant transaction streams, the system of internal control, governance arrangements and processes, and developments that could impact on its financial reporting.

15. Based on the risk assessment process, significant risks of material misstatement to the financial statements have been identified and these are summarised in Exhibit 2, page 8. These are the risks which have the greatest impact on the planned audit approach, and the planned audit procedures in response to the risks are outlined in Exhibit 2.

16. The risk assessment process is an iterative and dynamic process. The assessment of risks set out in this Annual Audit Plan and Exhibit 2 may change as more information and evidence is obtained over the course of the audit. Where such changes occur, these will be reported to the council and those charged with governance, where relevant.

Exhibit 2
Significant risks of material misstatement to the financial statements

Risk of material misstatement	Planned audit response
Fraud caused by management override of controls Management is in a unique position to perpetrate fraud because of management's ability to override controls that otherwise appear to be operating effectively.	The audit team will: • Evaluate the design and implementation of controls over journal entry processing. • Make inquiries of individuals involved in the financial reporting process about inappropriate or unusual activity relating to the processing of journal entries. • Test journals entries, focusing on those that are assessed as higher risk, such as those affecting revenue and expenditure recognition around the year-end. • Evaluate significant transactions outside the normal course of business. • Assess the adequacy of controls in place for identifying and disclosing related party relationships and transactions in the financial statements. • Assess changes to the methods and underlying assumptions used to prepare accounting estimates and assess these for evidence of management bias.
Valuation of Dwellings The council held £508m of dwellings assets at 31 March 2024. The valuations of dwellings are significant estimates. Valuations are based on a specialist beacon approach and management assumptions, changes in which can result in material changes to valuations. Dwellings were revalued during 2023/24 as part of the council's 5 year rolling programme. Values may also change year on year, and it is important that the council ensures the financial statements accurately reflect the value of dwellings.	The audit team will: • Review management's assessment that the value in the balance sheet of assets not subject to a valuation process in 2024/25 is not materially different to current value at the year-end, and challenge this where required.

Risk of material misstatement	Planned audit response
Valuation of Other Land and Buildings (OLB) The council held £1,043m of other land and buildings assets at 31 March 2024. The council is required to value OLB assets at existing use value where an active market exists for these assets. Where there is no active market, these assets are valued on a depreciated cost replacement (DRC) basis. As a result, there is a significant degree of subjectivity in these valuations which are based on specialist assumptions, and changes in the assumptions can result in material changes to valuations. All OLB assets are revalued on a five-year rolling basis. Values may also change year on year, and it is important that the council ensures the financial statements accurately reflect the value of OLB.	The audit team will: • Evaluate the design and implementation of controls over the valuation process. • Review the information provided to the valuer and assess this for completeness and accuracy. • Evaluate the competence, capabilities, and objectivity of the valuer. • Obtain an understanding of management's involvement in the valuation process to assess if appropriate oversight has occurred. • Review the appropriateness of the key data and assumptions used in the 2024/25 valuation process, and challenge these where required. • Review management's assessment that the value in the balance sheet of assets not subject to a valuation process in 2024/25 is not materially different to current value at the year-end, and challenge this where required.

Source: Audit Scotland

Key audit matters

17. The Code of Audit Practice requires public sector auditors to communicate key audit matters. Key audit matters are those matters, that in the auditor's professional judgement, are of most significance to the audit of the financial statements and require most attention when performing the audit.

18. In determining key audit matters, auditors consider:

- Areas of higher or significant risk of material misstatement.
- Areas where significant judgement is required, including accounting estimates that are subject to a high degree of estimation uncertainty.
- Significant events or transactions that occurred during the year.

19. The matters determined to be key audit matters will be communicated in the Annual Audit Report. Exhibit 2 outlines the significant risks of material misstatement to the financial statements that have been identified, including those that have greatest impact on the planned audit procedures and require most attention when performing the audit.

Group audit

20. Dundee City Council is part of a group and prepares group financial statements. The group is made up of five components, including the council which is the parent of the group. Risk assessment procedures have been performed on the group audit to identify if there are any risks of material misstatement to the group financial statements, or any components where audit procedures are required for the purposes of the group audit. The outcome of the risk assessment procedures on the group audit are outlined in Exhibit 3.

Exhibit 3
Outcome of risk assessment procedures on the group audit

Group component	Accounting treatment	Risk of material misstatement	Audit procedures required	Auditor
Dundee City Council	Consolidated on a line-by-line basis	Yes – Exhibit 2	Yes – full scope audit	Audit Scotland
Leisure & Culture Dundee	Consolidated on a line-by-line basis	No – not material to group financial statements	Analytical procedures at group level	Henderson Loggie
Dundee City Common Good Fund	Consolidated on a line-by-line basis	No – not material to group financial statements	Analytical procedures at group level	Audit Scotland
Fleming Trust	Consolidated on a line-by-line basis	No – not material to group financial statements	Analytical procedures at group level	Audit Scotland
Tayside Contracts	Accounted for on equity basis	No – not material to group financial statements	Analytical procedures at group level	Audit Scotland
Dundee City Integration Joint Board	Accounted for on equity basis	No – not material to group financial statements	Analytical procedures at group level	Audit Scotland

Source: Audit Scotland

21. Where audit procedures are required on a component's financial statements, and the component auditor is different to the council's appointed auditor, group audit instructions will be issued to the component auditor outlining expectations and requirements in performing these audit procedures.

Audit of the trusts registered as Scottish charities

22. The preparation and audit of financial statements of registered charities is regulated by the Charities and Trustee Investment (Scotland) Act 2005 and the Charities Accounts (Scotland) Regulations 2006. The 2006 Regulations require charities to prepare annual accounts and require an accompanying auditor's report where any legislation requires an audit. The Local Government (Scotland) Act 1973 specifies the audit requirements for any trust fund where some or all members of a council are the sole trustees. Therefore, a full and separate audit and independent auditor's report is required for each registered charity where members of the council are sole trustees, irrespective of the size of the charity.

23. Elected members of the council are the sole trustees for 6 trusts registered as Scottish charities, with total assets of some £14.6 million. The first four trusts listed below have adopted the "connected charities" provision whereby the accounts are collated into a single document and are known collectively as the Dundee City Council Charitable Trusts:

- Belmont Trust Estate: charity number SC018900
- Camperdown Estate Trust: charity number SC018899
- William Dawson Trust: charity number SC018920
- Hospital Fund: charity number SC018896
- Fleming Trust: charity number SC052182
- Lord Provost of Dundee Charity Fund: charity number SC027022

24. Fiona Owens, of Audit Scotland, has been appointed by the Accounts Commission as external auditor of the charities, for the period from 2024/25 until 2026/27. The 2024/25 financial year is the third year of Audit Scotland's five-year audit appointment.

25. Fiona and the team are independent of the charitable trusts. The Ethical Standard requires auditors to communicate any relationships that may affect the independence and objectivity of the audit team. There are no such relationships to communicate pertaining to the audit of the charities.

26. The trust balances are disclosed in a note in the council's Annual Accounts. They do not represent assets of the council so are not included within the council's single entity balance sheet, although the Fleming Trust is consolidated into the group accounts.

27. Our duties as auditors of each of the registered charities administered by Dundee City Council are to:

- express an opinion on whether the charity's financial statements properly present the charity's financial position and are prepared in accordance with charities legislation.
- read the Trustees' Annual Report and express an opinion as to whether it is consistent with the financial statements.
- report on other matters, by exception, to the Trustees and to the Office of the Scottish Charity Regulator (OSCR).

28. The trustees have primary responsibility for ensuring proper financial stewardship of public funds, compliance with relevant legislation and establishing effective arrangements for governance, propriety and regularity that enable the trusts to successfully deliver their objectives.

29. Based on our risk assessment, we have identified one significant audit risk for each Trustees' Annual Report and Financial Statements, being "fraud caused by management override of controls". Our response to this risk includes the same audit procedures as set out in Exhibit 2.

Materiality levels for the 2024/25 audit of trusts registered as Scottish charities

30. Materiality levels for the trusts are set out in Exhibit . During the audits we will also apply our risk based professional judgement to the extent of testing required of non-material account areas to reflect the needs of users of the accounts.

Exhibit 4
2024/25 Materiality levels for charitable trusts

Materiality	Dundee City Council Charitable Trusts	Lord Provost Charity Fund	Fleming Trust
Planning materiality: 2 per cent of net assets based on audited 2023/24 financial statements	£120,000	£835	£170,000
Performance materiality: 75 per cent of planning materiality	£90,000	£625	£127,500
Reporting threshold: 5 per cent of planning materiality	£6,000	£42	£8,500

Source: Audit Scotland

31. The Code of Audit Practice includes provisions relating to the audit of small audits. In light of the volume and lack of complexity of the financial transactions, we plan to apply the less complex body provision of the Code to the 2024/25 audit of the charities.

32. No significant risks in the wider scope areas or Best Value were identified from the risk assessment process for the charitable trusts.

33. Our work on the Trustees' Annual Report and Financial Statements of the charities will be undertaken in line with the council audit timetable set out in Exhibit 4. The charitable trusts accounts will be scrutinised and approved by Dundee City Council's Scrutiny Committee on behalf of the trustees.

Wider scope and Best Value

34. Reflecting the fact that public money is involved, the Code of Audit Practice requires that public audit is planned and undertaken from a wider perspective than in the private sector. The wider scope audit set out by the Code of Audit Practice broadens the audit of the annual accounts to include consideration of additional aspects or risks in four wider scope areas, which are summarised below:

- **Financial Management** – this means having sound budgetary processes. Factors that can impact on the council being able to secure sound financial management include the strength of the financial management culture, accountability, and arrangements to prevent and detect fraud, error and other irregularities, bribery and corruption.

- **Financial Sustainability** – this means looking forward over the medium and longer term in planning the services to be delivered and how they will be delivered effectively. This is assessed by considering the council's medium- to longer-term planning for service delivery.

- **Vision, Leadership and Governance** – this means having a clear vision and strategy, with set priorities within the vision and strategy. This is assessed by considering the clarity of plans in place to deliver the vision and strategy and the effectiveness of the governance arrangements to support delivery.

- **Use of Resources to Improve Outcomes** – this means using resources to meet stated outcomes and improvement objectives through effective planning and working with partners and communities. This is assessed by considering the council's arrangements for ensuing resources are deployed to improve strategic outcomes, meet the needs of service users, and deliver continuous improvement.

35. A conclusion on the effectiveness and appropriateness of arrangements the council has in place for each of the wider scope areas will be reported in the Annual Audit Report.

Best Value

36. Under the Code of Audit Practice, the audit of Best Value in councils is fully integrated within the annual audit. As part of the annual audit, auditors are required to take a risk-based approach to assessing and reporting on whether the council has made proper arrangements for securing Best

Value, including follow up of findings previously reported in relation to Best Value.

37. The Accounts Commission also reports nationally on thematic aspects of councils' approaches to, and performance in, meeting their Best Value duties. As part of the annual audit, thematic reviews, as directed by the Accounts Commission, are conducted on the council. The thematic review for 2024/25 is on the subject of service transformation and involves considering how the council is redesigning services to maintain outcomes and deliver services more efficiently. Conclusions and judgements on the thematic review will be reported in a separate Management Report and summarised in the Annual Audit Report, where required.

38. At least once over the five-year appointment, the Controller of Audit will report to the Accounts Commission on the council's performance in meeting its Best Value duties. The second year of this programme runs from October 2024 to August 2025. A Controller of Audit report on Dundee City Council was presented to the Accounts Commission in November 2023.

Significant wider scope and Best Value risks

39. No significant risks in the wider scope areas or Best Value were identified from the risk assessment process.

Reporting arrangements, timetable and audit fee

Audit outputs

40. The outputs from the 2024/25 audit include:

- This Annual Audit Plan.
- An Independent Auditor's Report to the council and the Accounts Commission setting out opinions on the annual accounts.
- An Annual Audit Report to the council and the Accounts Commission setting out significant matters identified from the audit of the annual accounts, conclusions from the wider scope and Best Value audit, and recommendations, where required.

41. The matters to be reported in the outputs will be discussed with the relevant officers for factual accuracy before they are issued. All outputs from the audit will be published on Audit Scotland's website, apart from the Independent Auditor's Report, which is included in the audited annual accounts.

42. Target dates for the audit outputs are set by the Accounts Commission. In setting the target dates for the audit outputs, consideration is given to the statutory date for approving the annual accounts, which is 30 September 2025 for local government bodies.

43. The Independent Auditor's Report and Annual Audit Report are planned to be issued by the target date of 30 September 2025.

Audit timetable

44. Achieving the timetable for production of the annual accounts, supported by complete and accurate working papers, is critical to delivery of the audit to agreed target dates. Exhibit 4 includes a timetable for the audit, which has been agreed with management. Agreed target dates will be kept under review as the audit progresses, and any changes required, and their potential impact, will be discussed with the council and reported to those charged with governance, where required.

Exhibit 4
2024/25 audit timetable

Audit activity	Dundee City Council target date	Audit team target date	Scrutiny committee date
Issue of Annual Audit Plan		31 March 2025	23 April 2025
Issue of Best Value Management Report		25 June 2025	25 June 2025
Annual accounts:			
• Consideration of unaudited annual accounts by those charged with governance	25 June 2025	N/A	25 June 2025
• Submission of unaudited annual accounts and all working papers to audit team	By 30 June 2025	N/A	N/A
• Latest date for audit clearance meeting	3 September 2025	3 September 2025	N/A
• Issue of draft Letter of Representation, proposed Independent Auditor's Report, and proposed Annual Audit Report	N/A	10 September 2025	24 September 2025
• Agreement of audited and unsigned annual accounts	10 September 2025	10 September 2025	N/A
• Approval by those charged with governance and signing of audited annual accounts	24 September 2025	N/A	24 September 2025
• Signing of Independent Auditor's Report and issue of Annual Audit Report	N/A	24 September 2025	N/A

Source: Audit Scotland

Audit fee

45. Dundee City Council's audit fee is determined in line with Audit Scotland's fee setting arrangements. The proposed audit fee for the 2024/25 audit is £456,600. A separate fee of £8,100 applies to the audit of the charitable trusts.

46. In setting the audit fee, it is assumed that the council has effective governance arrangements in place and the complete annual accounts will be provided for audit in line with the agreed timetable. The audit fee assumes there will be no significant changes to the planned scope of the audit. Where the audit cannot proceed as planned, for example, due to incomplete or inadequate working papers, the audit fee may need to be increased.

Other matters

Internal audit

47. It is the responsibility of the council to establish adequate internal audit arrangements. The council's internal audit function is provided by its internal audit section, which since October 2022 has been led by a Chief Internal Auditor on a shared basis with Angus Council.

48. While we are not planning to place formal reliance on the work of internal audit in 2024/25, we will review internal audit reports and assess the impact of the findings on our financial statements and wider scope audit responsibilities.

Audit quality

49. Audit Scotland is committed to the consistent delivery of high-quality audit. Audit quality requires ongoing attention and improvement to keep pace with external and internal changes. Details of the arrangements in place for the delivery of high-quality audits is available from the Audit Scotland website.

50. The International Standards on Quality Management (ISQM) applicable to Audit Scotland for 2024/25 audits are:

- ISQM (UK) 1, which deals with an audit organisation's responsibilities to design, implement, and operate a system of quality management (SoQM) for audits. Audit Scotland's SoQM consists of a variety of components, such as: governance arrangements and culture to support audit quality, compliance with ethical requirements, ensuring Audit Scotland is dedicated to high-quality audit through engagement performance and resourcing arrangements, and ensuring there are robust quality monitoring arrangements in place. Audit Scotland carries out an annual evaluation of its SoQM and has concluded it complies with this standard.

- ISQM (UK) 2, which sets out arrangements for conducting engagement quality reviews, which are performed by senior management not involved in an audit, to review significant judgements and conclusions reached by the audit team, and the appropriateness of proposed audit opinions on high-risk audits.

51. To monitor quality at an individual audit level, Audit Scotland carries out internal quality reviews on a sample of audits. Additionally, the Institute

of Chartered Accountants of England and Wales (ICAEW) carries out independent quality reviews on a sample of audits.

52. Actions to address deficiencies identified by internal and external quality reviews are included in a rolling Quality Improvement Action Plan, which is used to support continuous improvement. Progress with implementing planned actions is monitors on a regular basis by Audit Scotland's Quality and Ethics Committee.

53. Audit Scotland may periodically seek the views of the council on the quality of audit services provided. The audit team would also welcome feedback at any time.

Dundee City Council

Annual Audit Plan 2024/25

Audit Scotland, 4th Floor, 102 West Port, Edinburgh EH3 9DN
Phone: 0131 625 1500 **Email: info@audit.scot**
www.audit.scot

AS.5.0

ITEM No …10……..

REPORT TO: **SCRUTINY COMMITTEE - 23 APRIL 2025**

REPORT ON: **OTHER REPORTS RELEVANT TO THE REMIT OF THE SCRUTINY COMMITTEE**

REPORT BY: **CHIEF INTERNAL AUDITOR**

REPORT NO: **130-2025**

1.0 PURPOSE OF REPORT

This report advises members of reports submitted to Tayside Contracts, Tayside Valuation Joint Board, Tay Road Bridge Joint Board, and Tay Cities Regional Deal Joint Committee that are relevant to the work of the Scrutiny Committee.

2.0 RECOMMENDATION

Members of the Committee are asked to review the reports listed at Appendix 1 and determine whether any of the reports should be the subject of a more detailed discussion by this Committee.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

This report summarises reports that have been reported to the Tayside Contracts Joint Committee, and the Tayside Valuation and Tay Road Bridge Joint Boards from 10 September 2024 to 17 March 2025.

5.0 POLICY IMPLICATIONS

This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6.0 CONSULTATIONS

The Council's Leadership Team have been consulted in the preparation of this report.

7.0 BACKGROUND PAPERS

None.

CATHIE WYLLIE, CHIEF INTERNAL AUDITOR **DATE: 1 APRIL 2025**

Committee	Report Title/Summary
Tayside Contracts Joint Committee **Special Meeting 27 January 2024**	Agenda and reports are available at: Publications **Reports of particular interest:** JC1/2025 External Audit Annual Report and Final Accounts It was reported that the Managing Director would be retiring on 1 June 2025, with arrangements for the appointment of his successor being established. Programme of meetings Monday, 27th January, 2025 - 10.00am (Special Meeting) Monday, 10th March, 2025 - 10.00am Monday, 16th June, 2025 - 10.00am Monday, 25th August, 2025 -10.00am Monday, 17th November, 2025 - 10.00am
Tayside Contracts Joint Committee **10 March 2025**	Agenda and reports are available at: Publications **Reports of particular interest:** JC06/2025 Schedule of Agreed Activities JC07/2025 Fleet Asset Management Plan 2025-2030 JC08/2025 External Audit -Annual Plan JC09/2025 Review of performance Reporting to Joint Committee
Tayside Valuation Joint Board **18 November 2024**	Agenda and reports are available at: Minutes & Agendas 2024 - Tayside Valuation Joint Board **Reports of particular interest**: TVJB 26-2024 Internal Audit. This report includes the annual plan for 2024/25, with the following audits planned: • Council Tax • Maintenance of Accuracy of the Electoral Register • Cyber Security • Follow-Up Review Financial reports 2023/24 TVJB 27-2024 External Auditors Report on the 2023/24 Audit TVJB 25-2024 Response to the external Auditors Annual Report on the Audit of 2023/24 TVJB 24-2024 Annual Accounts for the year ended 31 March 2024 Programme of meetings Monday, 27th January, 2025 - 9.00am Monday, 16th June, 2025 - 9.00am Monday, 25th August, 2025 - 9.00am Monday, 17th November, 2025 - 9.00am

Tayside Valuation Joint Board **27 January 2025**	Agenda and reports are available at: Minutes & Agendas 2025 - Tayside Valuation Joint Board **Reports of particular interest**: TVJB3-2025 Revenue Budget 2025-26 to 2029-30 TVJB4-2025 Review of Policy & Procedures for Dealing with concerns at work (Whistle Blowing)
Tay Road Bridge Joint Board **2 December 2024**	Agenda and reports are available at: December 2024 Board Papers | Tay Road Bridge **Reports of particular interest:** TRB 33-2024 Health & Safety Monitoring TRB 30 2024 2023/2024 Audited Accounts including the external auditor's annual report TRB 28 2024 Revenue Budget 2025/2026 to 2027/2028 TRB 29-2024 Capital Plan 2025/2026 to 2027/2028 Programme of meetings Monday, 17th March, 2025 - 10.00am Monday, 9th June, 2025 - 10.00am Monday, 8th September, 2025 - 10.00am Monday, 1st December, 2025 - 10.00am
Tay Road Bridge Joint Board **17 March 2025**	Agenda and reports are available at: March 2025 Board Papers | Tay Road Bridge **Reports of particular interest:** TRB 04-2025 Strategic Plan 2025-2030
Tay Cities Region Deal Joint Committee **13 December 2024**	Agenda and reports are available at: https://www.taycities.co.uk/sites/default/files/2024-12/TC131224ag.pdf **Reports of particular interest:** Tay Cities Regional Economic Strategy - Prospectus for Regional Growth 2025-2035